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The paradox of the perfect physiotherapist the integration of disabled students into the physiotherapy profession

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The Paradox of the Perfect Physiotherapist: the Integration of Disabled Students into the Physiotherapy Profession.

By

Joanne Elizabeth Opie.

September 2015



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**A thesis submitted in partial fulfilment of the
University's Requirements for the Degree of
Doctor of Philosophy.**

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Abstract

The corpus of literature about disabled therapists within physiotherapy omits one important factor: the experiences of disabled physiotherapy students. Therefore, this research aimed to fill this gap by exploring the integration of disabled students into the physiotherapy profession. This participatory research sought to investigate the phenomenon from multiple perspectives to incorporate the voice of disabled students, an analysis of the policies which regulate the profession, and the opinions of representatives from the Chartered Society of Physiotherapy and the Health and Care Professions Council.

In stage one of the project ten disabled physiotherapy students were recruited. These students completed narrative interviews and Kawa drawings to document their experiences. Stage two explored the available information for prospective disabled students by conducting an internet survey. Finally in stage three, the policies of the Health and Care Professions Council and Chartered Society of Physiotherapy were examined for ableist language and then two representatives from each organisation were interviewed about the integration of disabled students. The data collected were analysed by critical narrative analysis with the student participants contributing to the generation of categories and themes. Further analysis was conducted using Bourdieu's Theory of Practice and the SEAWall model of discrimination.

My research has identified two paradoxes that affect the integration of disabled students. Firstly, the paradox of the perfect physiotherapist, applied via a narrow physiotherapy corporeal standard, which particularly limits access for people with physical impairments. Secondly, the paradox of supporting students whilst maintaining qualification standards. Again this limits access for disabled students, particularly when fitness to practise standards are applied during the admission process. These competing imperatives create a dilemma for disabled students around disclosing their disability status. This dilemma will only be solved by reducing discrimination at all levels of the system. However, in order to achieve this change, disabled physiotherapists and students will need to adopt a more affirmative orientation to disability to act as facilitators of change within the profession.

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Referencing within this thesis¹

¹ This thesis is referenced using the Harvard style specific to Coventry University called 'CUHarvard'. This reference style requires the use of page numbers in in-text citations for direct quotes, but also for paraphrasing or summarising ideas expressed within a section of a book or an article. Thus the page number is only omitted when the whole article or book is paraphrased or summarised.

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Glossary of Abbreviations

BIS	Department for Business, Innovations and Skills
CSP	Chartered Society of Physiotherapy
DDA 1995	Disability Discrimination Act 1995
DRC	Disability Rights Commission
DSA	Disabled Student Allowance
HCPC	Health and Care Professions Council
HCP	Healthcare Professional
HE	Higher Education
HEE	Health Education England
HEFCE	Higher Education Funding Council for England and Wales
HEI	Higher Education institution
HPC	Health Professions Council
ICF	International Classification of Functioning, Disability and Health
LETB	Local Education Training Board
NHS	National Health Service
PSED	Public Sector Equality Duty
QAA	The Quality Assurance Agency for Higher Education
UCAS	The Universities and Colleges Admission Service

Chapter One: Introduction

“An author in the proper sense of the word is someone who makes public things which everyone felt in a confused sort of way.” (Bourdieu 1990a:81)

1.1 Introduction

This thesis documents my exploration of the integration of disabled students into the physiotherapy profession. This original research sits within a constructivist epistemology, using a Bourdieusian analysis of the multiple factors which influence the successes of disabled students in becoming physiotherapists. It considers the experiences of disabled students, including the specific skills they can contribute to the profession, in conjunction with an evaluation of the field of physiotherapy education, with its positive and negative effects on disabled students. This introduction provides a brief general background context for the discussion to follow and creates an overall picture of the thesis as a whole. Bourdieu emphasised the importance that any social research should be underpinned by the reflexivity of the researcher (Wacquant 1992:36). Consequently, I begin this introduction by considering the factors which were the basis of my decision to explore the topic of disabled physiotherapy students. Social constructionism also requires research to be situated within a social and historical context. This introduction sets the socio-historical scene of this study by discussing the situation for disabled students accessing higher education (HE), both in terms of general statistics and also existent research about disabled students in HE. Subsequently, I state my research questions, and address the issue of terminology used within the thesis, and finally give an overview of the contents of the thesis as a whole.

1.2 My interest in this Research

I qualified as a physiotherapist in 1986, working clinically for twenty four years; the last twelve of these were within learning disability and paediatric services. Part of this time was spent working within special and mainstream schools with children presenting with varying levels of functional abilities. My clinical philosophy was always to focus on the child's ability first and then on

areas where improvements could be gained. Whilst I was working in paediatrics the Disability Discrimination Act 1995 (DDA 1995) was extended to include education, which required the paediatric physiotherapy service to become familiar with the requirements of this legislation in order to ensure the service we were offering was responsive to the children's needs.

When I moved into academia, towards the end of 2001, I was invited to take on the role of learning support tutor based on my knowledge of the disability legislation and specialist knowledge of neurodiverse conditions, such as dyspraxia and dyslexia; the majority of physiotherapy students disclosing a disability presented with dyslexia. I was both learning support tutor and a member of the admissions team; it was also the time when HE was brought within the remit of the DDA 1995. There was much uncertainty about the implementation of this Act within physiotherapy education and I realised that the first potential barrier for disabled students was the attitudes of admission tutors towards the inclusion of disabled students into the profession. Hence my MSc dissertation focussed on the admission of disabled students into physiotherapy, research which was subsequently published (Opie and Taylor 2008). At this time I was also appointed to the post of Faculty Learning Support Coordinator, liaising between the disability office, departmental learning support tutors and the faculty senior management team. I perceive one of the most important aspects of this role is to work as an advocate to support the integration of disabled students within the health professions, although I have become increasingly aware of the potential barriers that these students face. My MSc research established that some of these barriers may be due to a level of uncertainty about supporting disabled students from the admission tutors, which may be decreased by an increased understanding of the potential of disabled students. However, there was little literature available about disabled physiotherapists and none from the perspective of disabled physiotherapy students; a realisation that developed into my interest of exploring this issues within my doctoral studies, particularly from the perception of the disabled students themselves.

I do not qualify as having a disability according to the legal definition of disability, as my impairments do not produce any limitations on my day to day activities. However, neither am I completely healthy; I was diagnosed with having hypertension (ironically not long after moving into academia); have episodes of generalised anxiety disorder, which I have learnt to manage using mindfulness, and was diagnosed, and successfully treated, with skin cancer during my PhD studies. I was aware of the debate within disability studies (which I will discuss in the methodology chapter) of the appropriateness of non-disabled people doing disability research due to my MSc dissertation, so I wanted to try to ensure that although this research would be the topic of my PhD, that the study would be participatory and ultimately emancipatory research.

1.3 Setting the Scene

The Office for National Statistics (n.d) calculated that there were approximately 60 million people aged between 16-64 years old in the United Kingdom (UK) between January - March 2015, 10.5 million (17.5%) of whom are classed as disabled (as defined by the Equality Act 2010). Whilst 73.4% of working-age people are employed, only 30% of disabled people within this category are in employment. The current Conservative, and previous Coalition governments are attempting to decrease the amount of public spending by implementing welfare reforms, along with encouraging disabled people into employment (Cross 2013:720), building on past initiatives (Smith & Towmey 2002), which included increasing the number of disabled people working for the National Health Service (NHS) (Department of Health 2000). Hirst and Thornton (2005) studied the increase of disabled employees in the public sector (including the NHS). They found that the NHS recruited 45,000 more disabled people from 1998 to 2004. However, although these figures show an increase in disabled people working within the public sector, there were still proportionally fewer disabled than non-disabled workers and the gap between these groups has not narrowed. One of the reasons for the persistence of this gap may be due to an erroneous perception that disabled people are not suitable to work in healthcare, particularly as health care professionals (HCPs), such as physiotherapists. The misconception may be held by the general public, but also physiotherapists

themselves. Therefore this research explored the experiences of current disabled physiotherapy students in order to suggest strategies for improving access to the profession. It also examined the policies and practices within physiotherapy education to see how supportive these are for disabled students.

1.4 Disabled Students in Higher Education

Entry into the health and care professions, working within and allied to the NHS, is through pre-registration qualifying programmes offered within HE. Since the government's widening participation policy was introduced in 1998 there has been an increase in students from non-traditional backgrounds, including disability, attending university. Between the years 1998-2008 the overall number of disabled students successfully qualifying on a degree programme in the UK rose from 11,052 (4.7% of the total students qualifying) to 26,531 (9.1% of total students qualifying)(Pumfrey 2010:44). However, on closer inspection of the figures the degree classifications gained by students with a disability are skewed towards the lower classifications; disabled students were less represented in the first and higher second class categories than non-disabled students (Pumfrey 2010:44-5). This reduced level of success has also been reported by Riddell, Tinklin and Wilson (2005:37), although Fuller *et al.* (2009:169) reported a more varied picture.

For the year 2013/14 there was a total of 61,845 disabled students in the first year of undergraduate education, approximately 11% of the total UK domiciled undergraduate population (576,150 students). The number of students enrolled on "subjects allied to medicine" courses was 144,380 students; 16,820 of whom had indicated a disability (approximately 11%)(Higher Education Statistics Agency 2015). However, there was no data as to how many of these students are on physiotherapy courses. This information was not published by the Higher Education Statistics Agency; the regulatory body for physiotherapy, The Health Care Professions Council (HCPC); or by the profession's governing body, The Chartered Society of Physiotherapy (CSP). It could be argued that collating this data and publishing it in recruitment information would help prospective students

with their career decision-making. If we are to encourage more disabled students into professions such as physiotherapy it is important to be able to inform potential students about the experiences of disabled students within physiotherapy. Although there is a gap in the literature about physiotherapy specifically, there is literature referring to disabled students in general.

1.5 Research into the Inclusion of Disabled Students in Higher Education

Since the extension of the DDA 1995 to education in 2001 there has been an increase in the literature about disabled students in HE in the UK. Two large scale research projects on the integration of disabled students into higher education were supported by grants from the Economic and Social Research Council: Riddell, Tinklin and Wilson (2005) and Fuller *et al.* (2009). The research by Riddell, Tinklin and Wilson (2005), occurred between 2001 and 2003, investigating the participation levels and experiences of students with different impairments in the context of key HE policies at that time. It included eight HE providers (three universities and one college in Scotland; two pre-92 and two post-92 universities in England). The ethos towards disabled students of each HE institution (HEI) was explored by reviewing policies, the provision of services, and by interviewing key personnel, such as senior managers and disability advisors. Forty-eight students attending the HEIs were recruited as participants to provide their perspective on the reasonable adjustments, accessibility and support provided by their institution. They also discussed their perceptions of self-identity with respect to disability. The findings of this study suggested the policies for promoting the inclusion of disabled students, were not always fully implemented often remaining as rhetoric rather than practical policy implementation. Learning support provision was generally better in post-92 institutions although all institutions seemed reluctant to encourage reasonable adjustments to assessment strategies in supporting students with dyslexia or in providing other support to students with different impairments. This reluctance demonstrated a concern in altering the standard provision which was often expressed by a need to maintain academic standards. Many support systems operated from an individual model of disability, requiring the student to organise all their own

support requirements, including the employment of carers and the negotiation of physical barriers. The students discussed a sense of self which had an ambiguous relationship with the status of disability; some students used their 'label' pragmatically, others resisted disability as a part of their identity. The authors highlighted the tensions felt by both students and academics as the DDA 1995 was implemented within HE. They identified disability advisers as agents for change in the provision of support for students, although pre-92 institutions were still seen as meritocratic and slow to implement this change. Finally they concluded that although much change had occurred since the introduction of the Act, the culture of HE in Britain was far from inclusive and future change would be dependent on future government policies.

The subsequent project by Fuller *et al.* (2009) focused on the experiences of disabled students (thirty-one students spread between four institutions throughout their courses), over a four year time span (2004-2007); considering factors which facilitated or inhibited their inclusion into full involvement of university life, both academic and social. Simultaneously, the views of university staff (senior managers, lecturers, and disability support officers: 28 people in total) were solicited about their perceptions of the inclusive nature of their respective establishments (2 pre-92 and 2 post-92 universities). The findings indicated a high level of variation in the perceptions of students about their support from the university; due to the resources within the university to provide support or due to students' expectations. Some students indicated a uniformity of provision based on diagnosis rather than individual requirements, whilst others reported delays in the application process and provision of equipment, or lack of training causing difficulties. It was noted that students who undertook work secondments reported better access to reasonable adjustments on campus compared to on placement, which was interpreted as due to uncertainty between the institution and the work providers. Overall the importance of staff attitudes was emphasised as being critical to student success. On the contrary, the views of the university staff focused on the development of policies in response to the legislation, rather than the implementation of reasonable adjustments for students. As before, some staff indicated concern that adjusting assessments

would compromise academic standards. Institutional and departmental culture was cited as having a major effect on the implementation of adjustments and consequently on the students' teaching and learning experiences. Whilst acknowledging the progress made in HE regarding supporting disabled students the authors stressed the need to continue this development. They recommended a move away from reactive, individual model provision, to a flexible curriculum that itself is designed to minimise barriers for disabled students.

Harrison *et al.* (2009) conducted another widespread project, undertaken on behalf of the Higher Education Funding Councils for England and Wales (HEFCE), to evaluate the provision and support for disabled students. This included a survey analysis of eighty-seven HE providers in England and nine in Wales, with response rates of 73% and 89% respectively. The surveys were augmented by visits to seven institutions (six in England and one in Wales). The findings identified that disability issues had become much more prominent in the culture of institutions over the preceding decade and disability was being considered in planning, admissions and curriculum developments. This shift in culture included an increased enthusiasm from key staff within the HEI for innovation and development of disability awareness. The authors suggested that, despite this general optimistic outlook, there were still students who were not accessing support and some students are still experiencing delays in the provision of their support packages, which can have major implications on their ability to succeed. Also there was an indication of a lack of embedding of disability issues in the central administrative practices of the HEIs and a lack of engagement by senior managerial staff. Finally the authors commented on the variability of the quality of provision between institutions with some offering excellent practice, whilst others failed even to offer sufficient information on websites.

Although these extensive projects indicate a move towards improved support for disabled students across HE, they have tended to focus at the general level. This identifies a gap in the literature, with limited research of

specific subject disciplines, especially those involved in health. Courses which confer a professional qualification alongside an academic degree not only have to respond to the policies within HE, but also those provided by their regulatory or professional bodies, such as the HCPC and CSP. This is the area in which physiotherapy sits, and as I will demonstrate in the following chapter, there is a considerable gap in the knowledge of how physiotherapy integrates disabled people into the profession. However, these general research projects do offer a framework to build upon with respect to the research design of my investigation.

1.6 Research Questions

The purpose of this exploratory study was to examine the integration of disabled students into the physiotherapy profession within England. The research was conducted from a constructivist epistemological perspective using a Mindful Inquiry approach (Benz and Shapiro 1998) and integrating a critical narrative analysis (Langdrige 2007:133-140) using a Bourdieusian lens to interrogate the text.

There were three main research questions:

1. What are the lived experiences of disabled physiotherapy students?
2. How do the policies and practices within physiotherapy affect the integration of disabled students?
3. What information is available to prospective disabled students considering physiotherapy as a career?

As can be seen from the above questions the aim of the research was to investigate the topic from multiple perspectives in order to gain as full a picture as possible of the situation for disabled students within physiotherapy education. Consequently, this required different data collection methods in order to answer the different research questions.

1.7 Terminology used within the study

This research endeavoured to represent the complexity of disability, recognising it as socially constructed (Shakespeare, Iezzoni and Groce 2009),

including multiple factors residing in both the individual and society (Bhaskar and Danermark 2006:288). Therefore, disabled people are represented as a heterogeneous group with many different impairments, who may face overlapping experiences of disablement or exclusion (Goodley & Lawthom 2006:2). Terms such as 'the disabled', 'dyslexics' etc. are not used (except where discussing stereotypes and group identity) as these imply homogenous groups of people. Students or people who are not disabled are referred to as non-disabled. The terms 'able bodied' or 'normal' will only be used to indicate their social construction and within an analysis of the oppression that society exerts on disabled people.

The terms 'disabled student' and 'disabled people' are used throughout this study. This usage is favoured by the British disability movement to signify that disability is socially constructed. Oliver (2009:90) stated that the term 'disabled student or person' denotes three factors: self-perception as a disabled person, the presence of an impairment, and the experience of externally imposed restrictions. Although the social model of disability places the concept of disability within the wider socio-political context, this research considers the integration of disabled people into the physiotherapy profession in light of the Equality Act 2010. Therefore, the definitions for disability and discrimination used will be those defined within this legislation. However, it must be acknowledged that these definitions are entrenched in the individual model of disability, where a person is disabled by their impairment rather than socially constructed barriers.

1.8 Overview of the Content of the Thesis

All constructivist research paradigms require the acknowledgement of the socio-historical nature of the topic (Cresswell 2007:21). Thus chapter two investigates the social construction of the concept of disability from a socio-historical perspective, which determines the origins for the generalised negative attitudes towards disabled people. This chapter also includes a critique of the different models of disability, considering their usefulness for understanding disability, identifying the Critical Realist model (Bhaskar and Danermark 2006) as

addressing the majority of factors which contribute to disability. Chapter three continues exploring the socio-historical context of this research focussing specifically on physiotherapy, considering this with respect to the research questions posed earlier in this introduction. As the corpus of literature within the physiotherapy field is very small I incorporated research from other health profession courses regulated by the HCPC. This review of the physiotherapy profession demonstrates that physiotherapists hold similar attitudes towards disability as the general public.

In order to explore disability I needed to establish a theoretical perspective which would encompass a pluralistic consideration of disability. Thus chapter four reviews the ontological and epistemological paradigms, identifying constructivism as the epistemology most appropriate to this research. Subsequently different theoretical perspectives within constructivism are discussed; whilst many of these theories consider the effects of structure on the individual, few of them discuss the effects of agency. Of the two theories that consider the interplay between structure and agency, Giddens (1990) offers a grand theory, whilst Bourdieu (1977) offers a theory which has developed from empirical research, which fits most closely with my conception of the structure of society and offers the required diversity to explore disability.

Bourdieu's approach cannot be neatly placed within any particular theoretical paradigm, using concepts which could fit in many different perspectives (Bourdieu 1990a:28). Crystallization (Ellingson 2009), Mindful Inquiry (Benz and Shapiro 1998) and Critical Narrative Analysis (Langdrige 2007) are similar approaches to qualitative research that combine methodologies, methods and analysis to facilitate a deeper exploration of the topic. My research design is based on these three approaches, which is explained in chapter five. One issue in conducting research into disability is to address the concerns of disabled theorists about the objectification of disabled people (Oliver 2009:110). This chapter discusses the processes that I have included in the research design to ensure that it is participatory in its approach and, hopefully, emancipatory in its

outcomes. This chapter also serves to introduce the reader to my research participants, some of whom eventually became my co-researchers.

The findings chapters have been framed using Bourdieu's key concepts of Habitus (chapter six), Practice (chapter seven), and Field (chapter eight). Chapter six compares and contrasts the social and educational history of two students with the same impairment to determine the similarities and differences that contributed to the development of their habitus and the different levels of capital that they possess. Chapter seven concerns practice, which reveals the social interactions between habitus and field. Practice incorporates the strategies agents use to manage their identity in order to establish a professional persona, to gain position by utilising their different forms of capital, and by negotiating their learning requirements. The final findings chapter (eight) explores how the general stereotyping of disabled people affects the view of disabled students entering professional education. It also explores the tensions between the competing agendas of HE, government legislation and the professional regulations with respect to disabled physiotherapy students.

Chapter nine is an overarching discussion which includes the participants' recommendations for change at the individual, institutional and structural levels of society. This chapter serves to develop the findings from physiotherapy education to HE provision in general and ultimately to society at large. Finally, the conclusion returns to the research questions to establish whether these were met and then to discuss the unique contributions to knowledge that this study has made, whilst reflecting on the difficulties and limitations that transpired during the project, concluding by suggesting areas for further research.

1.9 Summary

This introduction has served to identify my interest in this area of research whilst briefly outlining the context of the study to establish an appropriate gap in the literature. I have documented the research aim and subsidiary questions

along with the terminology which will be used throughout the thesis. The statistics suggest that although more disabled people are entering employment this has not resulted in a change in the proportion of disabled people working within the NHS, possibly because of a notion that disabled people cannot become health professionals. This research was intended to investigate whether this was the case, by working with disabled physiotherapy students to explore their experiences in order to encourage more disabled physiotherapy students into the profession.

Chapter Two: The Social Construction of Disability

“Human societies are amazing and complex phenomena” (Evans and King 2006:5)

2.1 Introduction

As previously stated, the constructivist paradigm stresses the importance of understanding the social and historical context of the topic of research. Therefore, this is a critical chapter which acts as an anchor to establish the roots of the modern concept of disability within Britain. It will argue that disability is a socially constructed concept, originating in the industrial revolution of the 18th Century. Therefore I use the term people with impairments rather than disabled people to emphasise the social construction of disability within the historical review. When considering the development of societies the forefathers of sociology (Marx, Weber and Durkheim) acknowledged the importance of understanding the historical background (Hughes, Sharrock and Martin 2003:15). Yet they had conflicting views on the roles of religion within the historical context: Marx (1926) was dismissive defining it as “the opium of the people”, contrastingly Durkheim and Weber considered an understanding of religions as an important basis for comprehending the development of society (Bellah 2006:4). As this research is situated in England the discussion will focus on the development of Northern European societies; specifically within England, which has been shaped by Greco-Roman philosophy and mythology, and Christianity. All of these factors have in turn impacted on the acceptance of disabled people within our society. This historical overview will serve to establish that the negative attitudes, oppression and discrimination towards disabled people are longstanding and deeply entrenched.

Once the socio-historical context is established the different models of disability are reviewed to evaluate them as a basis for a contemporary understanding of disability. This includes comparing and contrasting the traditional individual model of disability, based on the socio-historical context; with the social model, developed from the disability movement of the mid-20th century.

Within the individual model disability is located in the individual with an impairment and is often defined as:

“A lack of adequate power, strength, or physical or mental ability; incapacity”.

or

“A physical or mental handicap, especially one that prevents a person from living a full, normal life or from holding a gainful job”.

(Dictionary.com 2012).

However, since the 1970s, disabled people have rejected these types of definitions as oppressive, replacing them with a definition that views disability as socially constructed. Thus a new definition of disability was offered by the Union of the Physically Impaired against Segregation:

“[Disability is] The disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities. Physical disability is therefore a particular form of social oppression” (Union of the Physically Impaired against Segregation 1976:14).

In critically appraising these opposing models of disability, I demonstrate that they are polarised models; neither gives a complete picture of the experience of disability. Subsequently, I consider more inclusive models such as the International Classification of Functioning, Disability and Health (ICF), offered by the World Health Organisation (World Health Organisation 2002) and critical social models based on the principles of feminism and critical theory. This chapter concludes by establishing the Critical Realist Theory (Bhaskar and Danermark 2006) as the model which I feel gives the most complete perspective of the complex nature of the experience of disability.

2.2 A Socio-historical Narrative of Disability

The Romans first landed on the British Isles in 55 BC bringing with them their culture, based on Ancient Greek philosophy and Roman mythology (Cavendish 2005). Quarmby (2013:26) argued that this culture contained negative perceptions of disabled people, which are still prevalent in today's society: contempt, scapegoat, stigma, spectacle, lacking in humanity and needing banishment or segregation are all attitudes towards disabled people that can be traced back to these cultures. Since the arrival of Christianity in 597AD (BBC 2011) English society became influenced by the role of the Church. The early Catholic Church shared power with the state to maintain the social order (Bernauer 2005:558), teaching that impairments were related to sin. Medieval people were superstitious and these teachings associated impairments with evil within the minds of the people. Consequently, a child born with an impairment was considered to be a punishment of the sins of their parents, or adults, particularly females, with an impairment were thought to be involved with witchcraft (Barnes 1991). Although, in the 16th Century, the spread of Protestantism challenged the social order contributing to the English Reformation (Bellah 2006:41), it did very little to change the views of the people towards impairment. Yet the church provided support for those individuals who had been rejected by society, for example providing shelter in a monastic hospital, which is the origin of the concept of charity and the modern hospice movement. This period of time is the first point in history where the state made provision for disabled people in the Poor Law of 1601. Funds were provided to the family or friends of disabled people to enable them to support them within their community (Barnes 1991). It might be argued that this is the first demonstration of the paradox that faces disabled people: on the one hand being shunned, whilst being the target of altruistic actions from the people who rejected them. Bellah (2006:42) stated that the Protestant Reformation was essential for the period of Enlightenment that followed.

The period of the Enlightenment (17th - 18th centuries) is heralded as the genesis of modern scientific, rational society. A society in which multiple

possibilities exist, but man [*sic*] is essentially secular, materialistic and irreligious; being concerned mainly with their own existence (Bellah 2006: 45-7). Durkheim contended that this pluralistic society creates a continual tension between individual rights and collective cohesion and expressed concern about the increased importance given to individual autonomy (Hughes, Sharrock and Martin 2003:164-8). This tension may be seen as a further paradox for the person with an impairment: to exert their autonomy, risking rejection or to attempt to assimilate into the collective by hiding their impairment. The Enlightenment stimulated the industrial revolution of the 18th - 19th century bringing great change, moving from an agrarian to industrial society (Haralambos and Holborn 2000: 7). Oliver (2009: 91) and Marks (1999: 80) identified this industrialisation as the genesis of the concept of disability. Until this time people with impairments had their place within agricultural society as a productive member of the community, working at their own speed and ability. Once capitalism located work in industrial towns and mechanised production increased the tempo of work, people with impairments became increasingly less able to participate in employment, reducing their overall productivity within society. Within a capitalist society a person's worth is judged on their ability to produce and people who are unable to contribute are judged negatively. Thus, dis-ability was created by capitalist societies in the form of physical and social barriers limiting the ability of people with impairment to participate in society. Consequently people with impairments became segregated and some even institutionalised.

Oliver and Barnes (2012:61-63) claimed that during this period of industrialisation the institutionalisation of people with severe disabilities gradually increased with them being placed in hospitals, asylums, workhouses and prisons. Quarmby (2013: 43-47) documented the standards of most of these institutions as being appalling with high levels of abuse inflicted on inmates; practices that are still being reported today within care and children's homes. The Victorian era introduced the idea of differentiating disabled people into groups, e.g. the aged and infirm within the workhouse system, which Barnes (1991) claimed is the origin of the control given to the medical profession over disability: being strengthened by the instigation of the Welfare state and the 1948 National Health

Service Act. Oliver (2009:93-4) claimed that the institutionalisation of people with impairments continued to increase over the 19th century as a means of social control. The state eliminated people who did not, or could not, conform to the image of normal. This view mirrors Foucault's theory which identified this period as the time in which the state increased the surveillance of the populous, using medical professionals as a tool to achieve this scrutiny (Billington, Hockey and Strawbridge 1998:18).

One consequence of the institutionalisation of people with impairments was the ease of access for the curious to observe "the unfortunates" (Quarmby 2013:41). The Victorian era was a notorious period for the visiting of institutions, such as Bedlam (now Bethlem hospital), and freak shows in circuses as entertainment for the gentry (Quarmby 2013:41). French and Swain (2012:49-51) reported that this practice of spectacle, of objectification of disabled people, continued within the health service in the form of medical curiosity during hospital appointments: consultant case demonstrations, or in photographing "unusual presentations" without seeking consent, particularly from disabled children. However, across the course of the 20th century, this segregation of disabled people began to reduce, although Oliver (2009:94) asserted that this was due to the financial costs of these large institutions rather than the ideology of community care.

Nonetheless one area where disabled people have continued to be segregated is within education. The 1944 Education Act required all children to receive an education, including those with a disability. However, until the late 20th century this education was often segregated within the special school system (Barnes, Mercer and Shakespeare 1999). This exclusion of disabled children severely limited their cultural capital. The dominant system had very little expectation of their intellectual abilities and therefore the education of the children was of a low standard (Liasidou 2013:306; Sutherland 1981:45). Borsay (2011:16) accused the special school system of limiting disabled people's employment prospects due to low expectations. Even now, in the 21st century,

integration of disabled children has not been fully achieved. Special schools still exist, although the population of these is usually restricted to those children with profound and multiple learning disabilities, whilst integration into mainstream schools is limited to the school that the local education authority has assigned to be modified to accommodate disabled children. Furthermore, Hyder and Tissot (2013:10) and Murray (2006:34) mentioned numerous cases of disabled children being educated in mainstream schools yet who are still isolated due to the attitudes of the teachers, the accessibility of the environment, and resource issues. It might be theorised that the segregated education system reinforced the collective consciousness that people with impairments were different and should be kept separate, not integrated into the mainstream society. This limits the ability of children with impairments to strive for membership within professional groups as they may have limited educational achievements. Those students who do attain the required academic qualifications may be advised against their physiotherapy career goal by teachers or parents who consider that disabled people cannot be physiotherapists. They may also receive this discouragement from within the profession either due to the same assumption, or to maintain professional identity.

One factor that may have contributed to the increased integration of the education system throughout the 20th Century was the rise in equality and rights based political movements (Thomas 2012:212). By the middle of the century there were many marginalised groups campaigning for equality, such as women, ethnic minorities and homosexual people. Gradually these all received legislative protection in the various anti-discrimination laws. In the 1970s a number of disabled people throughout Europe were also becoming more politically aware, forming the Disability Movement in Britain (Thomas 2014:9). The experiences of key people within the organisation are recalled in a book written by Campbell and Oliver (1996). They claimed that the disability movement could be seen as a social movement because it was founded on the political consciousness of those involved and the representation of disabled people **by** disabled people. In response to the activities of these empowered groups social views towards disability began to change, which can be documented from the 1975 United

Nations Convention on the Rights of Disabled People (United Nations n.d.) culminating in the acknowledgement of the social model of disability and the creation of the DDA 1995 in Britain. However the implementation of this legislation did little to change views about disabled people in general with the dominant attitude associating disability with inadequacy, inability and abnormality (Beauchamp-Pryor 2012a):255).

Although the first decade of the 21st Century saw the DDA 1995 strengthened and subsequently replaced with the Equality Act 2010, the global economic crisis at the end of that decade caused governments in all of the G20 countries to focus on decreasing welfare expenditure through processes of welfare reform (Briant, Watson and Philo 2013:875). In Britain these reforms were initiated by the Labour government with the introduction of the work capacity assessment for all people on incapacity benefit and have been added to by subsequent governments. Resultantly all disabled people claiming benefits have undergone reassessment of their eligibility, performed by agencies appointed by the State, with the underlying neoliberal principle of encouraging participation in society via independence and productivity (Penketh 2014:1486). The Conservative government has justified these reforms by promoting the concept of a “big society” which includes a requirement of people to also be capable, competent and independent, to look after themselves and their community rather than relying on the State via welfare support (Runswick-Cole and Goodley 2011:881) and by using the social model of disability as justification (Morris 2011:3). These new developments have introduced yet another paradox for disabled people: being told you are disabled, but no longer disabled enough to receive welfare support. Goodley, Lawthom and Runswick-Cole (2014:982) claimed that all of the changes to welfare have resulted in disabled people being “the poorest of the poor”: 60% of disabled people in Britain and the USA have incomes below the relative poverty level (Oliver 2009:100). The rhetoric around the welfare changes has also served to reawaken negative attitudes towards disabled people, who are perceived as unproductive, dependent, and incompetent and a drain on society (Briant 2013:884; Runswick-Cole and Goodley 2015:2). This increase in discrimination is mirrored by a 75% increase in

incidences of disability hate crime in England and Wales between 2008 and 2009 (Quarmby 2013:214).

These negative attitudes towards disabled people, developed over the course of history, are extremely entrenched within society. The dominant, non-disabled, group project their values of 'normal' on disabled people. This creates oppression of disabled people with the general view of disability being an individual personal tragedy which prevents the person from being a valuable, productive member of society. If these assumptions are deeply held then it is likely that they are also held by many physiotherapists, which may potentially impact on the way in which these therapists welcome and interact with students who have impairments. Therefore an awareness of these negative assumptions is essential for a critical exploration of the way in which disabled people are integrated into the physiotherapy profession.

2.3 Models of Disability

This view of disability as a tragic limitation of a person's productivity and value is referred to as the individual model of disability and is challenged by disabled activists who offer an alternative model: the social model of disability, which locates disability within the barriers that people with impairments face in their day to day lives. These models are oppositional, as explained in the following section, which concludes by describing more recent models which consider both a person's impairments and the many other social factors which contribute to disability.

2.3.1 The Individual or Personal Tragedy Model

This model is used to explain the reactions to impairments as a consequence of the socio-historical background of disability. The Individual model associates a person's disability with their impairment: the person is said to **'have'** a disability. The whole problem is seen as residing in the individual and their misfortune at not being 'normal' or 'able bodied'. The origins of this approach have been discussed above, but are also associated with the idea of a

person being an individual and equality being related to sameness (Billington, Hockey and Strawbridge 1998:57). This is the dominant model of the Western society (French and Swain 2012:4) and can be seen in the two dictionary references cited in the introduction to this chapter. Both place the disability within the individual with one linking it to capacity and the other linking it to normality. If the disability resides in the individual then it is their problem to deal with and any concessions that other people or society make are altruistic. Hence we have a massive charity industry that has grown up around disability.

These charities often use the personal tragedy model to encourage donations. Major televised fundraising events, such as 'Children in Need' and 'Comic/Sport Relief', often portray a negative or tragic image of disabled people. This reinforces the stereotypical 'needy', 'apologetic' or 'grateful' roles for disabled people, whilst giving to these charities underpins the self-esteem and superiority of the dominant group. The personal tragedy model looks at disability as "unmanageable suffering, a life subject to constant dependence and without value" (Hosking 2008:13). This perspective leads to fear and avoidance of people with disabilities. Moreover, it admires those people who have risen above or overcome their disability to achieve something. Although the portrayal of this successful "Superhuman" image (Channel 4 2012) might be seen as positive affirmation, it is actually still a negative image creating a disabled role model that few people can hope to emulate (Tregaskis 2004:27). Many disabled activists refer to this as the 'Supercrip' ideal (Oliver 2009:23).

2.3.1.1 Stigma and the Corporeal Standard

It might be argued that the superhuman portrayal is a means of countering the concept of stigma. Goffman (1990:1) suggested that stigma links disability to deviance or a spoiled, 'abnormal' identity. He identified three types of stigma: "abominations of the body" (difference from the ideal physical appearance); "blemishes of character" (based on behaviour thus it includes mental well-being, but also dishonesty and criminal behaviour), and "tribal stigma" (associated with ethnic identity and religious belief). The attitude of the general public to people possessing stigma is negative: they are perceived as "not quite human" and

stigma theories are developed to justify their negative treatment and “to account for the danger they represent” (Goffman 1990:4-5). Goffman argued that this stigmatization occurs in relational contexts, based on social norms and stereotypes. Therefore, when we meet a new person we are assessing them against social norms; any deviation from the norm upsets the interaction. People with a hidden impairment can manage interactions in order to limit the amount of information they impart socially, allowing them to pass as normal. Conversely, a person with a visible impairment can do nothing to hide this and consequently have to try to manage the situation in order to minimise the tension within the interaction (Winance 2007:628). This social awkwardness was the basis for a disability awareness campaign by Scope in 2014, called “End the Awkward”. They depicted a number of social interactions between disabled and non-disabled people, which were frozen at the awkward point and then acceptable solutions were offered.

In a development of the theory of stigma, (Scambler 2009) argued that Goffman’s hypothesis did not consider the effects of the social structure on these personal interactions. He reasoned that stigmatization exists alongside exploitation and oppression. He developed ideas that stigma and deviance are analytically different and therefore should not be used interchangeably. Stigma represents “an ontological deficit [which]...invokes shame” whilst “deviance refers to a moral deficit [which causes]... blame” (Scambler 2009:450). He suggested that neither concept exists outside of socially constructed norms. In the current welfare reforms the stigma of disabled people is being changed into deviance (the moral norm being prescribed by the neoliberal importance of work and independence); thus disabled people are blamed for not working, which is apparent in the increase of hate crime towards disabled people (Quarmby 2013:214).

When considering people with impairments they are often compared to a socially constructed idealisation of the normal body: the corporeal standard. This comparison has become known as ableism and is defined as “a network of

beliefs, processes and practices that produce a particular kind of self and body (the corporeal standard)...that is projected as perfect, species-typical and therefore essential and fully human" (Campbell 2001:44). The classification of normal is dependent on how close a person's body is to the socially defined corporeal standard. For example, in previous centuries, the wearing of spectacles was rare and would be classed as abnormal, yet in the modern era wearing glasses is very common and accepted within the corporeal standard. The corporeal standard includes a hierarchy of bodily traits (Zitzelsberger 2005:389), which is validated by the non-disabled gaze (Lingsom 2008:3; Loja *et al.* 2012:193). If people do not conform to this embodied touchstone a hierarchy of disability exists with those more compatible to the standard, and most able to be economically productive, being the most accepted (Deal 2003:898). Therefore, disabled people who are able to make their impairment less visible and adapt to the norm gain greater acceptance.

2.3.2 The Medical Model

The medical model of disability is aligned to the individual model, giving power to medical professionals (French and Swain 2012:106). This power has arisen from the historical employment of doctors by the state to categorise people based on their ability to produce work, granting them expert status, giving them the ability to enforce treatment on people in order to attempt to regain 'independence' or 'normality'. Although recent governments have tried to address this power imbalance with concepts such as the 'Expert Patient' (Department of Health 2001) medical professionals are still used as gatekeepers (French and Swain 2012:109). It can be argued that this power is also based on Talcott Parson's role theory, especially the operation of the sick role. Parsons claimed that all individuals within the system occupy a role which is determined by, and determines, their status e.g. mother, teacher, and doctor. Each of these roles has expected behaviours associated with it, which convey a moral value and are institutionalised within the social system. Consequently, if a person does not act in the manner expected of that role we feel personally affronted and shame is imparted onto the person (Sharrock, Hughes and Martin 2003:29-31). When a person is ill they can no longer fulfil their allocated roles, yet this is accepted on a temporary basis as the sick role and the person is expected to

seek assistance to return to a healthy state in order to resume their normal role. Within this process medicine functions to assist the person to regain health (Bury and Monaghan 2013b:92-93). Thus the sick role imparts power to health professionals to impose treatments onto people who are ill, who are in turn obliged to accept this treatment. Anyone occupying the sick role for longer than expected or showing no signs of seeking help are censured by society (Sharrock, Hughes and Martin 2003:41-42). The sick role is deeply entrenched within the medical model of disability and within medical practice; patients who do not follow medical advice are labelled as non-compliant or non-adherent. Even the label patient implies a passive acceptance of medical advice. These perceptions are often extended to disabled people, who are expected to want treatment to reduce or remove their impairments, e.g. deaf people accepting cochlear implants. Also disability is often, quite erroneously, associated with sickness (Oliver 2009:44).

Similarly, Thomas (2012:215) identified that medical sociology continues to replicate socially constructed idealisations in what she referred to as a “social deviant paradigm”, developing oppositional constructs of ‘normal’ versus ‘deviant’ and ‘normal’ versus ‘pathological’. She compared this with the use of a “social oppression paradigm” within disability studies. Other marginalised groups represent their exclusion from ‘normal’ using terms such as racism, sexism, ageism and homophobia. Therefore disability studies have introduced the term *disablism* to denote:

“The social imposition of avoidable restrictions on the life activities, aspirations and psycho-emotional well-being of people categorised as ‘impaired’ by those deemed ‘normal’. *Disablism* is social-relational in character and constitutes a form of social oppression in contemporary society” (Thomas 2012:211).

Thomas continues by emphasising that, in the same way that it is no longer acceptable to discuss race, gender or sexual preference with the notions of ‘normal’ or ‘deviant’, it should be no longer acceptable to consider disability in these terms either.

One consequence of the medical model of disability is that the initial diagnosis of an impairment is made by a doctor, which leads to disability being associated with ill health and sickness i.e. disability is “an individual problem requiring medical treatment” (Oliver 2009:93). In the case of HCPs the professional’s goal is to return the patient to their pre-morbid state or to functional independence (usually defined by the HCP rather than the client) (Winance 2007:626). However, French and Swain (2012:4) identified that disabled people understand independence as the opportunity for self-determination, control and management of their everyday living. If this includes paying for assistance for activities they cannot do, it is still independence. Yet, the internalisation of the medical model and the linking of disability with the sick role results in disabled people feeling obliged to seek cures or treatments to make themselves ‘normal’ and ‘acceptable’, and those that reject this expectation are viewed as rule-breakers or having “developed an unhealthy response to their impairments” (Hoskins 2008:12). Barnes(1996:ix), whilst writing the forward for Campbell and Oliver’s *Disability Politics* book, condemned medical and therapy services, and charities as being in the “Disability Industry” which is dependent on disabled people for their survival. Therefore, these organisations encourage this internalisation and striving for ‘normal’, reinforcing the oppression and discrimination of disabled people.

2.3.2.1 Oppression and Discrimination

The prevalence of the individual and medical models throughout English society causes oppression of disabled people. Northway (1997) discussed the different forms oppression may take. She contends that disabled people at a societal level face cultural imperialism (internalisation of the dominant culture), discrimination, marginalisation, powerlessness and potential violence. At the same time Reeve (2006) highlighted the personal and emotional effects of oppression within structural disability, social interactions and internalised oppression. Many disabled people feel the need to conform to the socially constructed idea of ‘normal’ and ‘able’ (Liasidou 2013:300 & 302). One form of this conformity is called normalisation, where the disabled person attempts to pass as normal and to only associate with non-disabled people (Tregaskis 2004:15-16). This results in a person who is ashamed or embarrassed by their

impairment and who tries to minimise their difficulties. The consequences of all forms of oppression may include a lack of self-confidence, poor self-esteem, denial, worthlessness and disempowerment. Disabled people often adopt roles to cope with these feelings, such as the grateful/ needy/ superhuman person, that sustain the self-fulfilling prophesy of stereotypes of disabled people (Reeve 2006). If disabled people act out of these expected roles using assertiveness and self-determination they are then labelled as troublesome and problematical (Northway 1997). However, Watermayer (2012) argued that there has been little investigation into how negative attitudes are internalised by disabled people.

It is argued that within the education system, including HE, normalisation can be seen in phrases such as 'additional needs' or 'special needs' where the disabled student is given extra support or resources, again in an attempt to conform to the 'normal' educational expectations (Gable 2014:89). Unfortunately, this is reinforced within legislation in the concept of reasonable adjustments being provided to help the student to achieve the 'normal' standard or to 'repair' the child so that they can be a contributing adult (Penketh 2014:1487). However, the word 'reasonable' is often interpreted as applying a cost limit to the adjustments (Clark 2007:212) which implies that there are some people that are not valued enough for adjustments. This is still the prevalent system for supporting disabled students, and whilst there is evidence that students who disclose their disability do well in this system there is also a suggestion that this structure is failing students who do not disclose (Madriaga et al. 2011):913 & 915). Further oppression is demonstrated in lower expectations of disabled children within the education system, which could lead to reduced educational opportunities (Liasidou 2013:306) and poor qualification outcomes. Thornton (2005:67) stated that disabled people are twice as likely as non-disabled people to leave school with no formal qualifications, which limits career prospects, condemning many disabled people to poverty and further oppression.

The oppression of disabled people is operationalised by stereotypes, prejudice and discrimination. Together these depersonalise the disabled person

and often act as self-fulfilling prophecies, forcing the person into a disabled role, which then justifies the stereotyping (Sutherland 1981:56). Thus the concept of disability is applied to people with impairments, by society, with a negative central unchanging tenet linking impairment to unproductivity, tragedy and dependence. Discrimination can exist at all levels of society, at the structural/ macro; institutional/ meso or individual/ micro levels. The 'SEAWall' model of discrimination (table 2.1) denotes discrimination as a wall, the foundation stones of which are **Structural** barriers, which occur at the macro level, comprised of social divisions between groups of people. Above these are **Environmental** barriers, occurring at the institutional or meso level, between the individual and their social or physical environment, whilst **Attitudinal** barriers, situated within the individual or micro level, involve the individual interactions between disabled people and non-disabled people, are the coping stones of the wall (Swain, French and Cameron 2003:2).

Attitudinal (individual/ micro)	Cognitive Prejudice: Assumptions (stereotypes)		Emotional Prejudice: Fear (prejudice)	Behavioural prejudice: (Discrimination)	
Environmental (institutional/ meso)	Disablist Language	Institutional Policy: rules & regulations	Professional practice: Medical paternalism	Inaccessible Environments.	
Structural (Macro)	Hierarchical & power structures		Denial of rights	Structural inequalities: poverty	

Table 2.1: SEAWall of discrimination: Adapted from Swain, French and Cameron (2003:2)

Even after 20 years of anti-discrimination legislation negative attitudes towards disabled people are still in evidence, although of a more subtle variety. This more covert type of discrimination is referred to as aversive disablism, describing the internal conflict between a person's belief system and their desire to appear non-prejudiced and fair. Aversive disablists recognise that discrimination is wrong, but do not recognise their own prejudice and therefore the behaviours that they display are unintentional, although still discriminatory (Deal 2007). In response to this oppression and discrimination the disability social

movement developed in the 1970s, which sought to challenge the individual model of disability by the development of the social model.

2.3.4 The Social Model of Disability

The social model of disability locates the problems of disabled people within society as social, political and economic barriers (Oliver 2009:47). Marks (1999:79) explained that the restrictions that disabled people experience are not corollaries of their impairments, but the consequences of living in an exclusive and oppressive society, which Goodley and Lawthom (2006:3) claimed is a form of apartheid. An example of the segregation can be found in research conducted by Losinsky *et al.* (2003) into the accessibility of a university campus to wheelchair users. They found that although the campus was deemed to be wheelchair user friendly the routes between teaching rooms were much longer for students who were wheelchair users as they were only able to use wheelchair accessible entrances, which in some lecture theatres were via fire exits manned by the lecturer. The social model calls on all members of society to acknowledge these barriers and to work towards removing them (Tregaskis 2004:9). Initially the social model focused on the barriers in employment, but this then expanded to include economic concerns, independent living, the physical environment, and the education system (Thomas 1999:14).

However, there has been criticism of the social model suggesting that it is too extreme to locate all of disability within society (French and Swain 2012:8). Some people argue that the social model should also address impairment and personal experience (Shakespeare and Watson 1997:263). Yet, Hosking (2008:7) defended the social model, explaining that in its earliest form it needed to be an extreme opposite to the individual model in order to “overcome inertia”. Oliver (2009:52), one of the authors of the social model, justified their approach as being designed to consider the collective experience of disability: to formulate the experience of disability into a civil rights issue following on from sexism, feminism and racism (Thomas 1999:15). The social model has also been critiqued for being too socio-economically focused (Bhaskar and Danermark 2006:281). Shakespeare and Watson (1997:102) agreed, suggesting that a more

post-modernist approach was needed that recognises pluralism rather than the historical materialism of the original model. Although Thomas (1999:24) recognised that the economic emphasis is due to the authors of the social model being Marxists and therefore concentrating on the materialistic drivers of society. Further critiques have been that the model fails to address personal experience, dual discrimination, or cultural issues (French and Swain 2012:8). However, Oliver (2009:48) refuted the former explaining that the model was developed from the personal experiences of the authors. Finkelstein (2001:4) suggested that any focussing on personal experience is only allowable if it serves to move the collective forward and stimulate change in society. It has also been suggested that this lack of acknowledgement of personal experience and emotions is due to the leaders of the disabled movement all being men with physical impairments (French and Swain 2012:9). The lack of discussion of dual discrimination is acknowledged, but Oliver (2009 :49) claimed that the model could be amended to incorporate this in the future. Regarding cultural issues, he felt that the focus of the social model should be on materialism considering that the majority of disabled people live in relative poverty (Oliver 2009:49). Nevertheless, Oliver (2013:1025) indicated the major changes in society that the social model of disability has contributed towards: deinstitutionalisation; legal acknowledgement of discrimination; changes to the physical environment to facilitate mobility; inclusive education; subtitles available on televisions, and a growing public realisation of the marginalisation of disabled people. French and Swain (2012:10) reminded us that the disabled movement is still a young social movement and these oversights that have been identified will be addressed as the social model of disability continues to evolve. However, a number of people have called for a more inclusive model of disability that addresses all of the criticisms of the social model.

2.3.5 Beyond a Binary Division

One of the main criticisms of the social model was that it was too extreme creating a dichotomous structure with the individual model. Whilst the individual model positioned disability within the person, ignoring society; the social model located it within society, ignoring the person. Therefore, both models were considered to be insufficient and a middle ground was needed. This has resulted

in a number of proposed pluralistic models; one from the medical model, in the form of the World Health Organisation's (2002) 'International Classification of Functioning, Disability and Health' (ICF), whilst the social relational, critical disability and critical realist models developed from the social model.

2.3.5.1 The International Classification of Functioning, Disability and Health

The World Health Organisation (WHO) is a global organisation for "providing leadership on health matters,...setting norms and standards,..."(World Health Organisation 2013). Therefore, it has a very important role in influencing medical culture. In recent years many health professions have utilised the biopsychosocial approach to health developed by Engel in 1977, which encourages the consideration of psychological and sociological factors that impact on the person's health alongside the biological factors (Lewis 2007):299). Despite this, Lewis (2007:301) concluded that Engel's approach retains the medical model perspective as it merely considers the individual's biological, psychological and social factors, excluding factors external to the individual (Lewis 2007:307). Consequently the World Health Organisation developed the ICF as an international standard to describe and measure health and disability, incorporating individual and structural factors which influence a person's health. The ICF perspective is centred on health rather than disability, recognising that all people can encounter deteriorations in health resulting in the experience of disability. Therefore disability becomes "mainstream": "a universal human experience" (World Health Organisation 2002:2-3). It classifies health in relation to domains moving from an individual's functioning or disability to activities and then participation, claiming that these domains place a person's impairment into context (see figure 2.1) (World Health Organisation 2002:9). However, the disability movement refutes the inclusivity of this system, because it still initially focuses on the person and creates a causal link between impairment and disability (Barnes 2014:41; French and Swain 2012:7), although (Bickenbach 2008):657) suggested this misconception may be based on the manner in which the terms impairment and disability are used interchangeably throughout the document.

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Figure 2.1 The International Classification of Functioning, Disability and Health (adapted from World Health Organisation 2002:9)

In my clinical experience the ICF may be used to emphasise the impairment of the person as being the root cause of any subsequent problems with activity and participation, but this may be due to a conceptual linking with the biopsychosocial model. Whilst it may be used in this manner, focussing on the individual rather than on how society could improve things to help a person's participation (top down: see figure 2.1); it may also be used to explore the contextual factors that impact on a person's participation (bottom up: see figure 2.1). Symeonidou (2014:1272) analysed the ICF's usefulness and concluded that whilst it was applicable in a clinical situation, as a medical tool of assessment and classification, it ought not be used to develop social policies due to its classification role.

2.3.5.2 The Social Relational Model

The criticisms of the social model of disability led to a number of developments of the intrinsic idea that disability resides within the social context of the person with an impairment. Thomas (1999), using a feminist perspective, developed the 'social relational model' defining disability as "a form of social oppression involving the social imposition of restrictions of activity on people with impairments and the socially engendered undermining of their psycho-emotional wellbeing" (Thomas 1999:60). Reeve (2014:93) concurred that this model

considers both structural social barriers, and the emotional consequences of having impairments. Thomas (1999) claimed that these two factors are interactive and compound one another. She proposed that the psycho-emotional effects of impairment create barriers that restrict the person's self-identity. For example, being stared at in public can create feelings of not belonging or not being wanted, which impacts on the person's self-identity and self-esteem (Reeve 2014:93). Thomas (1999) stressed that disabled people are not passive victims, but develop coping strategies for resisting these emotional barriers, e.g. the use of humour or becoming an informal educator (Reeve 2006:96 & 99). However, both Reeve (2006:102) and Thomas (1999) acknowledged the expense that these coping strategies demand of the disabled person. So much so that at times their resistance crumbles and they internalise the feelings of not belonging, which affects their self-esteem and creates feeling of worthlessness.

The internalising of negative images and expectations can restrict the person's activities as they lack the confidence to confront the negative experiences they have been subjected to in the past. A person with a visible impairment may constantly rehearse how they are going to cope with curious questions about their condition. This is personal information that they may wish to keep private, but have to respond to probing questions about this sensitive issue, affecting their control on how much information they wish to relay to other people (Reeve 2006: 99-100). Goodley (2011) developed these ideas of the effects of disability on the psyche by suggesting the importance of incorporating some concepts from psychoanalysis into disability studies to help investigate the concept of disability (see chapter four).

2.3.5.3 Critical Disability Theory Models

Other models have emerged from post-modernism and post-structuralism. These focus on the cultural determinants of disability, tending to be grouped as critical disability studies (Thomas 2014:12). This approach includes a reflexive consideration of disability studies in the past combined with a realisation of the complexity of disability within a social context in which disability is constantly being redefined with respect to identity, embodiment and a neo-liberal political

system (Goodley 2013:632). Within this group Critical Disability Theory (CDT) defines disability as being:

1. A social construct, not the inevitable consequence of impairment
2. Best characterised as a complex interrelationship between impairment, individual response to impairment, and the social environment.
3. The social disadvantage experienced by disabled people is caused by the physical, institutional and attitudinal environment which fails to meet the needs of people who do not match the social expectations of normalcy.

(Hosking 2008:7)

It is apparent that CDT is an amalgam of all the models previously discussed and Hosking (2008:7) regarded it as a truly biopsychosocial model of disability as it considers the multidimensionality of disability by describing axes of oppression which intersect, creating an intersectional hypothesis. In instances of double oppression, e.g. a black disabled man or a white disabled woman, are axes that intersect and compound each other. Whereas in other instances an axis of privilege (white male) will intersect with a subordinate axis (disabled person). In this situation the man is inferior to a non-disabled man, but superior to a disabled woman. Therefore, this multidimensionality of axes reflects the multiple roles we all have when interacting in society (Hosking 2008:8-10). However, this is an abstract theoretical model, which is difficult to use empirically (Goodley 2013:641). Whereas, Bhaskar and Danermark (2006:280) offered their Critical Realist model as a meta-theory which identifies the multiple biological, psychological and social factors creating disability as layers which all interact together as a “necessary laminated system” referring to multiple levels of reality.

2.3.5.4 Critical Realist model

Critical realism takes the ICF definition of disability and applies this broadly to be maximally inclusive. Therefore, this theory can incorporate all of the other theories of disability (Bhaskar and Danermark 2006:280). The authors claimed that this is the most inclusive theory of disability and can also include other dimensions such as gender, ethnicity and sexual preference arguing that all the other models only privilege one factor above the others as contributing to disability. However, Critical Realism, acting as a meta-theory considers all of

these factors together and allows the application of theory to practice (Gable 2014:87).

Epistemology	Models of disability		Layers of factors affecting disability
Constructivism	Post-modern	Critical Realist	Cultural
	Social		Political
	Social Relational		Economic
Empiricist			Individual
	Psychological		
	Biological		
	Chemical		
	Genetic		

Table 2.2: Comparisons of Models of Disability. (Adapted from Gable 2014:94)

Gable (2014) offered a useful framework to explain Critical Realism in more detail (see table 2.2). The first column of table 2.2 indicates the epistemological theoretical perspective in which each model of disability is situated. Thus, research associated with the individual model sits within an empirical post-positivistic paradigm, providing epidemiological and causative understandings of disability. In contrast, research from the constructivist perspective provides understanding of the social context of the experience of disability. The critical realist perspective suggests that both of these paradigms assist to give an overall understanding of the complex nature of disability. The middle column demonstrates that the only model of disability to combine both approaches is the Critical Realist Model, which addresses all of the factors affecting disability (third column) in a laminar system. Whilst I feel that this model of disability is the most comprehensive of the models in current usage within disability studies, I also have reservations about its usefulness as a practical application of theory to practice, as claimed above. Although it identifies numerous layers of factors affecting the experience of disability it does not indicate how or if these layers interact with each other. I feel that in order to explore disability it is necessary to find a theory that helps to consider the potential interactions of these factors.

2.4 Summary.

Disability is a complex issue to explore and this chapter has served to emphasise this complexity. The socio-historical discussion provides a background against which the more modern understandings of disability can be situated. It also provides an indication of the deeply entrenched nature of the negative attitudes towards disability within our society. The discussion of the different models of disability demonstrates the oppositional nature of the two main models; the individual and social models. Although the social model has been criticised in the last twenty years, it did challenge the individual model, raising the profile of disability equality on the political agenda and gaining legislation against disability discrimination. The models of disability developed since the social model offer a more inclusive approach to understanding the complexity of disability, considering many more contributing factors other than solely impairment or society. Baskar and Danermark (2006) and Gable (2014) identified the Critical Realist model as incorporating all of the other models, including the ICF, a claim supported by the discussion within this chapter.

In order to investigate the experiences of disabled students within the physiotherapy profession, I need to position the physiotherapy profession and the education of physiotherapy students against this general socio-historical background. The following chapter will explore the development and regulation of the physiotherapy profession in respect of both attitudes towards disabled people and the models of disability adopted within the profession to provide more specific detail to inform the research questions posed in the introduction.

Chapter Three: Becoming a (Disabled) Physiotherapist

“As a profession portrayed as being... supportive of disabled... people, should not physiotherapists be the first to welcome them as their colleagues?”

(French 1987: 367)

3.1 Introduction.

A social constructivist epistemology requires an understanding of the historical and social context of the area of research. Whilst chapter two gave a general overview of the construction of disability within English society, this chapter provides essential background information for the exploration of the physiotherapy profession and the potential integration of disabled people within it. In order to answer my research questions it is necessary to consider the structure of the physiotherapy profession and the process of educating physiotherapy students, including the systems in place within the profession to encourage and support their integration. These systems are underpinned by policies developed by the agencies involved in the regulation of the profession. Therefore the legislation that impacts on physiotherapy and disabled students is discussed, particularly with respect to HE and the regulatory and professional bodies. Finally, the chapter considers the literature available for prospective disabled physiotherapy students to help them make their career choices.

3.2 The Physiotherapy Profession

Barclay (1994) charted the development of the physiotherapy profession from 1894 as the Society of Trained Masseuses across a century to the modern Chartered Society. The Society of Trained Masseuses was only open to females and its rules required patients to have a medical referral and members were limited to advertising in medical journals only. Therefore, from its earliest days the profession was strongly linked to medicine (Bentley and Dunstan 2006:11). This domination by the medical profession continued with the Chairperson of the profession being a doctor until 1972, when Lois Dyer became the first physiotherapist to chair the CSP. Subsequently, in 1978, physiotherapists gained professional autonomy; another move away from medicine's influence (Truland

2008:17). This longstanding historical association with the medical profession has left its mark; physiotherapy is arguably the most medicalised of the health care professions (Öhman, Hägg, and Dahlgren 1999:60). Although the profession has a wide and varied scope there is a great prominence of a biomedical conceptualisation of the body. As a profession we remain dominated by a biomedical and often a Cartesian understanding of impairment (Nicholls and Gibson 2010:500). One strategy used by the emerging profession to establish a core specific knowledge-base was to adopt a “body-as-machine” view. This also legitimised the provision of services in the early rehabilitation services; bodies were machines that could be mended by the application of physical techniques (Nicholls and Gibson 2010:499).

The legacy of the conceptualisation of body-as-machine can be seen in the definition of physiotherapy on the CSP website: “to identify and **maximise ... ability**... enabling people to **improve** their health, wellbeing and quality of life” (Chartered Society of Physiotherapy 2014) [my emphasis]. This definition emphasises ability, which is often interpreted as a need for physiotherapists to be physically able resulting in a general assumption of physical fitness and “sportiness” (Greenwood and Bithell 2005:75). The definition also focuses on what physiotherapists do rather than defining their core values and beliefs. Watson (2006:153) noted a similar problem within the occupational therapy (OT) profession in trying to define the essence of an occupational therapist, asserting that the basic tenet of OT should emphasise “being before doing”. Although, the CSP does identify core values, such as altruism and compassion (Chartered Society of Physiotherapy 2013:16), the majority of the documents outlining the detailed expectations of physiotherapists produced by the HCPC or CSP emphasise activity rather than values, reinforcing this central tenet of ability within the profession. Contrastingly, as discussed in the previous chapter, the general assumptions about disabled people include a lack of ability, unproductivity and dependence. These implicit assumptions of physical capability within the profession and incapacity of disabled people potentially have repercussions for the inclusion of disabled people as physiotherapists.

3.3 Disabled Physiotherapists

When considering the integration of disabled people into the profession, it becomes apparent that physiotherapy has a long association with visual impairment; the first blind candidates were accepted in 1895 (Barclay 1994:45). Subsequently, war-blinded servicemen were encouraged to train as masseurs (Barclay 1994:58), resulting in 109 ex-servicemen qualifying in the period between 1947 and 1957 (French 1995:7). Visually impaired physiotherapists were trained in the National Institute for the Blind school, affiliated to the City University in London until 1995 when the education of students with visual impairments was integrated into the general HE setting (French 1995:16). Even beyond this time students with a visual impairment were supported by a specific centre funded by the Royal National Institute for the Blind (this closed in 2012). This long association encourages the suggestion of physiotherapy as a potential profession to people with visual impairments, although some people suggest that the increased technical aspects of healthcare make it more difficult for someone with impairments (Marno 2010:628).

French (1988; 1995) documented the experiences of some disabled physiotherapists, including those with a visual impairment. Her first article reported on a qualitative study using semi-structured interviews with twenty-five disabled HCPs, seven of whom were physiotherapists. The findings indicated that the practitioners received mostly positive responses from colleagues and patients, although discrimination was also reported, particularly in admission to, and during, training. Whilst her participants reported an increased empathy with patients, she felt that this idea needed further exploration (French 1988:185). Her other article (French 1995) focused solely on physiotherapists with a visual impairment, including an historical account of the integration of visually impaired physiotherapists into the profession. Again, she conducted semi-structured interviews with forty-five participants, using their responses to punctuate her historical analysis. In her conclusion she alluded to the increasing technical and bureaucratic aspects of the profession as creating further barriers for

physiotherapists with visual impairments, along with a lack of flexibility within the work environment and society in general (French 1995:17).

Further barriers for disabled physiotherapists were exposed by French's (1987) survey of NHS physiotherapy departments throughout Britain. Her findings indicated that attitudes within the profession mirrored those within the wider society, although younger respondents (below 40 years old) were more positive. She suggested that social acceptability of disability may have more of an impact on acceptance than the limitation imposed by the impairment, with obesity in physiotherapists being ranked as less acceptable than therapists who were wheelchair users (French 1987:364). This links to the idea of the corporeal standard discussed in chapter two and suggests that physiotherapists may have a corporeal standard that is more restrictive when considering the ideal physique for a physiotherapist. Similarly, O'Hare and Thomson (1991) conducted a survey of twenty-three physiotherapists with post-qualification acquired physical disabilities. They found that although their participants stated an overall sympathetic response from colleagues and managers, the participants themselves suggested that physiotherapy was not a suitable profession for many disabled people and that developing a disability had negatively affected their career. Unfortunately, the article did not explore the basis of these negative comments, but it does suggest that physiotherapists with physical impairments face challenges within the profession.

However, this research into the experiences of disabled physiotherapists is twenty-five to thirty years old and predates the introduction of the DDA 1995 and the ICF (World Health Organisation 2002); both of which may have influenced the practices within the profession and facilitated the integration of disabled students. Nonetheless these papers do indicate that physiotherapists exhibit the same preconceptions about disability as the general public. In fact French (1987) and O'Hare and Thomson (1991) suggested that there might be a more stringent social construction of the corporeal standard for physiotherapists, particularly considering the ideal physique. This will have implications for disabled students

who have a physical impairment and they may encounter more difficulties than students who have sensory or hidden impairments. Although there is no current literature about the experiences of disabled physiotherapists it may be possible to generalise from the experiences of other disabled health care professionals (HCP) regulated by the HCPC.

One profession that physiotherapists work closely with is occupational therapy (OT). Sivanesan (2003) recounted her student journey as an OT with visual impairments. She began her paper by stating that attitudinal barriers are the hardest to overcome and that laws are only useful if society has the will to implement them. She discussed the feelings of being overwhelmed by the amount of extra work she had to perform compared to non-disabled students in order to succeed, finding support from peers and tutors invaluable. She recommended a national network to support disabled students, taking into account their individual impairment profiles. Her experiences of professional placements were varied with attitudes ranging from over-protectiveness to open-minded flexible support. She commented that being open enabled her to develop and also served to raise awareness in the professionals with whom she works. Likewise, (Runge and Carnduff 2009) recounted their experiences as OTs with polio. They discussed the similarities in their experiences, despite living in different European countries. They emphasised the importance of doing, creating, and participating both in their personal and professional lives. Yet they indicated that participation is not always possible for disabled people due to societal barriers.

For disabled HCP students these social barriers may occur either in the university or on clinical placements. Murphy (2011) documented the clinical experiences of student radiographers, who discussed the rewards and challenges of dyslexia within the radiography department. Like Sivanesan (2003), they recommended a national support forum for disabled students to exchange coping strategies. They also emphasised the importance of an understanding educator for a successful placement experience. The attitudes of other people,

including university tutors and professional colleagues, were identified as a major social barrier by five OTs within an ethnographic study by Bevan (2014). These attitudinal barriers were reported to have an enduring negative effect, lasting long after the initial interaction. In response to these attitudes the participants discussed the difficulty of disclosure of their impairments; some participants were open, whilst others used a need to know basis or chose not to disclose. Many of the participants indicated that organisational policies and procedures created further barriers for them entering and progressing in their career, indicating a gap between the administrative and practical responses to the Equality Act 2010. The difficulties of administrative practices were also identified by social work students (Stanley *et al.* 2011). The participants described disclosing their disability as a process involving numerous decisions and negotiations that they acknowledged were not without risk. The majority of participants expressed dislike for the terminology used, especially the term 'disabled person', which made them feel incapable and inferior. They reported confusion about fitness to practise regulations and the timing of disclosure to the regulatory body, which was seen as distant and impersonal.

Although most of these studies contain small samples sizes, making it difficult to generalise the findings, they do give examples of the experiences of disabled students and professionals, with differing types of impairment, which can be used as the basis for generating questions for further research into the area. They also serve to identify the gaps in the literature. Firstly, there has been no voice from disabled physiotherapy students since the implementation of the DDA 1995, which is a major oversight for research in this area. The voice of the student is most important when exploring disability, particularly research conducted by a non-disabled person, such as myself. Therefore, my research focused on the experience of disabled physiotherapy students. Yet it was not just sufficient for these students to be participants to collect data from, which was then analysed and interpreted. They were also invited to be involved as co-researchers throughout the whole project, including the dissemination. Secondly, the experiences related by these disabled HCPs raised the question of whether people with the same impairment experience disability in the same manner. The

use of terms such as ‘the blind’ or ‘the deaf’ indicate an assumption that all people with the same impairment share the same experience of disability. In the same way, the use of the term ‘the disabled’ suggests that all people with impairments have the same experience of disability, which is the basis of the uniform provision for disabled students described previously (Fuller *et al.* 2009). This was an important area to explore within my doctoral research in order to inform the most appropriate provision of support for disabled physiotherapy students.

These assumptions are held at a societal level and are an example of structural discrimination, as explained by the SEAWall model of discrimination (Swain, French, and Cameron 2003:2). In turn this structural discrimination forms the foundation for environmental discrimination, which includes institutional discrimination. In order to consider the barriers that disabled students may face in the form of institutional discrimination it is necessary to consider the regulation of the physiotherapy profession as a whole and specifically the education of physiotherapy students.

3.4 The Regulation of Physiotherapists

In 2001 the government introduced the regulation of a number of health and care professions (initially 13) by the introduction of the Health and Social Work Professions Order 2001. This legislation created the Health Professions Council to oversee those identified professions and to protect the public from mal-practice from registered health professionals. In 2013 social work was included and thus the legislation and council’s name were amended, creating the Health and Care Professions Council. The HCPC maintains a register of all HCPs practising within the UK available for public scrutiny. Entry onto this register can be made by people possessing a professional qualification and meeting the specific professional standards of proficiency.

The physiotherapy standards are set as the minimum level of proficiency for practising physiotherapists and included generic standards applied to all the HCPC regulated professions and then physiotherapy specific requirements (Health and Care Professions Council 2013). The HCPC has acknowledged that physiotherapists may not be able to meet all of the standards that apply to the whole profession, as a person's scope of practice may change. The important requirement is that each registrant considers their scope of practice and ensures that they are practising safely and effectively within that area. The document also highlights that they "do not dictate how you [the practitioner] should achieve these standards". (Health and Care Professions Council 2013: 4). This allows flexibility for disabled therapists, both within their scope of practice and the means by which they achieve the required standards.

Alongside these competency standards the HCPC has outlined the duties required of registrants concerning conduct performance and ethics (Health and Care Professions Council 2012a). This includes the obligation that registrants declare their fitness to practise (Health and Care Professions Council 2012b:2). On initial registration an applicant has to demonstrate their fitness to practise, by a self-declaration that they "do not have a health condition that would affect your [the HCP] ability to practise your profession" (Health and Care Professions Council 2012c:5). The HCPC explain that if the health condition or disability does not affect the registrant's practice, or if they have adapted their practice to adjust for their health or disability, then this does not have to be declared (Health and Care Professions Council 2012c:6). Once on the register the HCPC operates a professional self-regulation principle which expects all professionals to monitor their own fitness to practise (including health or disability) and to declare any changes that may affect their practice to the HCPC (Health and Care Professions Council 2012c:11). However, it is argued that fitness to practise regulations may be discriminatory, creating environmental barriers for disabled people (Ruebain *et al.* 2006:8).

The Disability Rights Commission (DRC) investigated professional regulations, suggesting that regulatory frameworks often imply a link between disabilities, competence and safety; creating negative attitudes within the professions towards practitioners with disabilities (Sin and Fong 2007; Sin, Fong and Momin 2008; Chih 2009). Since this investigation the DRC has been disbanded yet the ongoing requirement for proving fitness to practise may be creating barriers for disabled students, either in accessing HCP courses, or during their education programme. Although the self-declaration is not necessary until completion of qualifying programmes the HCPC requires courses to inform prospective students of health requirements and to consider the future fitness to practise of all students (Health and Care Professions Council 2014b:13). Consequently, many disabled applicants may not be able to negotiate the admissions process due to being perceived as unable to fulfil the professional requirements at the first point of application. The ways that the fitness to practise requirements are applied to disabled physiotherapy students is an important aspect to explore with both the student and HCPC participants.

Whilst the HCPC is the regulatory body for physiotherapy, the CSP is the professional body: setting additional standards for its members and responding to government legislation. The CSP require all qualified practising members to be registered with the HCPC and consequently they must meet both the HCPC's competency standards and the CSP's code of professional behaviours (Chartered Society of Physiotherapy 2011a:4&6). This code specifies the expectations of members' values and behaviours, which are underpinned by four principles: take responsibility for their own actions; behave ethically; deliver an effective service, and strive to achieve excellence. (CSP 2011a:4). Physiotherapists are able to self-assess their own practice against the CSP principles by using the Physiotherapy Framework, which allows the individual to identify areas of strengths (supported by evidence) along with areas for development. It includes four areas: values; knowledge; practice skills, and generic behaviours knowledge and skills (Chartered Society of Physiotherapy 2013:7). As previously discussed, many of the requirements are linked to ability and therefore may act as barriers for the integration of disabled physiotherapists,

particularly those with a physical impairment. It would seem that this factor is reinforcing this physical capacity assumption within the profession and this will need exploring with representatives from both organisations.

When considering disabled physiotherapists, both the HCPC and CSP are required to adhere to the Equality Act 2010. This Act incorporates the nine previous laws on anti-discrimination, and a further 100 statutory instruments of rules and regulations, into one Act (Government Equalities Office 2009). Within the Act Part Two: Chapter One defines the characteristics which are protected as: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or beliefs; sex, and sexual orientation (Equality Act 2010 s4). The definition of a disabled person is cited as being “a person (P) who has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities” (Equality Act 2010 s6). Part two: Chapter Two specifies the activities that are prohibited by law comprising of discrimination, harassment, and victimisation. In respect of disabled people it includes a category of “discrimination arising from disability”: treating a disabled person unfavourably due to something that is a consequence of their disability, unless it can be shown that this treatment is “a proportionate means of achieving a legitimate aim” or that the person did not know, or could not be expected to know, that the claimant had a disability (Equality Act 2010 s15). It also allows for positive action towards disability, i.e. a non-disabled person cannot claim they have been discriminated against if disabled people are treated more favourably (Equality Act 2010 s13). Finally, specific to disability, is the requirement that reasonable adjustments are made to provisions, criteria or physical features to reduce any disadvantage experienced by the disabled person (Equality Act 2010 s20).

Regulatory and Qualification Bodies, such as the HCPC and CSP, are required to ensure that the application of competence standards is not discriminatory unless they are a proportionate means of achieving a legitimate aim (Equality Act 2010 s.53). In other words competence standards may be

indirectly discriminatory for disabled applicants if they put them at a disadvantage, yet this is acceptable if the standard is meeting a “legitimate objective in a fair and balanced way”(Government Equality Office 2010: 6). Competency standards are also required to have reasonable adjustments applied to minimise any disadvantage experienced by disabled people (Equality Act 2010 s20). In light of the potential discriminatory effects of competence standards qualification bodies are required to ensure that they minimise the disadvantage for disabled people. Yet they are also charged with maintaining the qualification as a “reliable indication of the knowledge, skills and understanding” of the professional qualification and “maintaining public confidence in the qualification standards” (Equality Act 2010 s96). Therefore it is important that the HCPC and CSP demonstrate that all competency standards are applied to all applicants or professionals, not just disabled people, and that the application of this standard is a proportionate means of maintaining the standards of the physiotherapy profession (Swanton and Johnson 2004). One issue that the Equality Act 2010 does not legislate for is the interpretation of the wording of the standards. As previously discussed physiotherapists hold similar attitudes to disabled people as the general population and possibly apply more stringent requirements for disabled people who seek to become physiotherapists. Therefore they may interpret the wording of the HCPC and CSP standards strictly and literally, which will create barriers for disabled students at all levels of the SEAWall of discrimination. Therefore not only is it necessary to analyse the documentation of the HCPC and CSP, but it is also important to explore how these documents are interpreted by the participants representing these organisations, particularly with respect to educating disabled physiotherapy students.

3.5 Educating Physiotherapists

Originally physiotherapy education took place within the NHS, in schools allied to hospitals, but as the profession evolved physiotherapy education was incorporated into the HE sector, offering degree level qualifications (Barclay 1994: 274-5). Despite the courses being within universities the students continue to be funded by the NHS; an arrangement that has resulted in the governance of the physiotherapy education, as depicted in figure 3.1, with multiple involvement

from education, health and regulatory and professional bodies all contributing to the structure of the field of physiotherapy education.

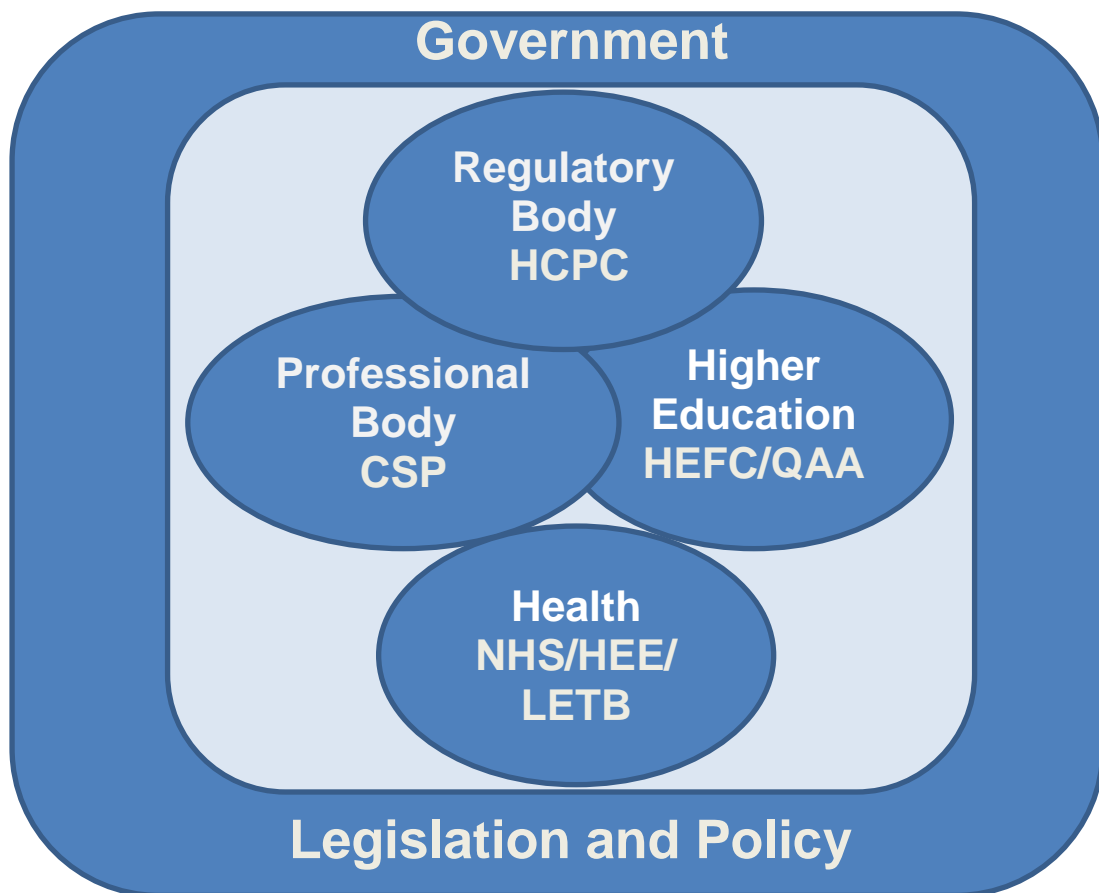


Figure 3.1: The Field of Physiotherapy Education

The boundaries of the field of physiotherapy education are set by government legislation including the Health and Social Work Professions Order 2001 and the Equality Act 2010 and monitored by government departments: the Department of Health and the Department of Business, Innovations and Skills. As physiotherapy education is delivered within the HE sector qualifying programmes also need to be responsive to the policies of the HEIs in which they are situated. The Quality Assurance Agency for Higher Education (QAA) is an independent body, similar to the HCPC, to assess the quality of universities and the courses offered. Public funding for HE is distributed by the Higher Education Funding Council for England (HEFCE), including the premium funding paid to the

institutions, which is intended to improve accessibility within HEIs, and Disabled Students Allowance (DSA), which is paid to individual disabled students to finance their support packages (Fuller *et al.* 2009:6). However, due to the historical links with health, funding for physiotherapy students comes from the NHS; a bursary for all students and the DSA for disabled students. Recent changes to the structure of the NHS have resulted in health professional education being the responsibility of Health Education England (HEE) which operates via 13 Local Education and Training Boards (LETB) (Health Education England 2015). This complex governance of the physiotherapy education arena with the involvement of three different governmental bodies overseen by two separate government departments may have implications for the integration of disabled students, particularly for the clinical aspects of their training. The HCPC and the CSP are the principal bodies that set the standards and codes of the profession and also the educational requirements for students.

The HCPC set standards of education and training (SETs) for professions within the register. As previously discussed, these require courses to ensure the potential to meet the fitness to practise requirements, although they also include a commitment to support disabled students during their training, maintaining a balance between supporting students yet ensuring professional standards (Health and Care Professions Council 2014b:53). The CSP produces learning and development principles that qualifying programmes are required to uphold when developing their curriculum; these encourage inclusive curriculum design and flexibility in assessment strategies (Chartered Society of Physiotherapy 2011b). Likewise, the QAA sets generic guidance for quality assurance for all HE courses, which outlines the legal requirements for the provision for disabled students and gives guidance for supporting disabled students throughout their student journey (Quality Assurance Agency for Higher Education 2010), and specific benchmarks for physiotherapy, which mirror the HCPC standards of proficiency and the CSP codes of behaviours (Quality Assurance Agency for Higher Education 2001). These agencies require academic staff to be supportive of disabled students on the one hand, but also to act as gatekeepers for the profession. Again the underlying attitudes of the academic staff will affect how

they interpret this paradoxical situation. These attitudes are often exposed when investigating practice within the field of professional education.

Hargreaves *et al.* (2014) conducted a survey across two NHS sites about knowledge and attitudes towards disability and also interviewed nine disabled students and six disabled HCPs. The findings indicated an acknowledgement of the prejudice within society against disabled people, which also affects the culture within the NHS. It highlighted the difficulties of implementing support for students within the NHS, which is focused on service delivery rather than education. Fitness to practise and patient safety were discussed, suggesting insecurity on the part of practice educators in the assessment of disabled students' fitness to practise. However, some of the disabled HCPs reported the positive values that they bring to practice, such as empathy towards patients. The authors concluded that greater disability awareness within qualifying programmes and NHS education would assist in the integration of disabled students and HCPs.

Disability awareness and supporting disabled students within physiotherapy education has been considered by three studies. Firstly, Atkinson and Owen Hutchinson (2005) discussed the use of the physiotherapy support service for students with a visual impairment. They considered the physiotherapy profession to be strongly underpinned by the medical model of disability, creating negative attitudes towards the idea of disabled people as therapists. Opie and Taylor (2008) focused on the admission process with respect to disabled physiotherapy students. This research sought consensus from admission tutors in England on the skills required by applicants and the challenges that they perceived in implementing the Act in the admissions process. Whilst the general tone of the findings was positive towards disabled students, a high level of uncertainty was evident, particularly about the level of physical or sensory impairment considered sufficient for practising as a physiotherapist. Finally, the difficulty of supporting disabled students on clinical placements was the focus of a study by Botham and Nicholson (2014). They identified that communication of

students' support needs between the university and placement required strengthening. This was achieved by the development of a proforma completed by the student with their academic tutor, which documented their needs to be used to facilitate discussion with the placement mentor. During the evaluation of the process the response rate from staff involved was poor, suggesting a potential culture of discrimination at an individual and institutional level, which would need to be addressed to facilitate further change. These articles all suggest that the culture within physiotherapy could be an environmental barrier for widening the inclusion of disabled students into the physiotherapy profession.

Professional culture was considered in a conference lecture given by Taylor (2007), discussing the diversity of the occupational therapy (OT) profession. She identified the predominance of the profession by white middle class females, which is not reflective of the constitution of UK society, and therefore OT clients. Increasing the diversity within the profession would challenge the inherent culture, citing the understanding of independence as an example; the OT philosophy being based on the medical model: doing for self, this was challenged by the social model: choosing for self. She elaborated that increasing diversity within the profession would also bring assets, such as the increased empathy that disabled therapists possess.

As regulatory and governing bodies, the HCPC and CSP assess and validate all physiotherapy courses in the UK and also the ongoing professional development of qualified physiotherapists. Consequently, it would be expected that these institutions will have a highly influential effect on physiotherapy culture and the integration of disabled students into physiotherapy. Therefore, the influence of both organisations on the culture of the profession and the guidance on supporting disabled students is explored in this research. One means of supporting disabled students is by providing them with information, particularly for prospective students seeking to become physiotherapists.

3.6 Information Available for Prospective Students

Both the HCPC and the CSP have produced guidance documentation regarding disabled practitioners. The HCPC produced a document in 2005, in response to qualification bodies being brought within the remit of the DDA 1995. The guide not only offers advice to disabled people but also to university admissions staff on the recruitment and selection of disabled applicants (Health Professions Council 2006). In 2013 the HCPC decided to revise this document and therefore commissioned research to investigate the most appropriate content for future documentation. The draft guide, based on the findings from this research, was available for consultation in 2014. This draft document is more student-focused including an overview of the application process, studying on a course and finally applying to the HCPC for registration, giving helpful advice in each section. This is supported by case studies and examples taken from existing disabled health care students both in the document itself and also available on the website as podcasts. The information for staff has also been expanded to include education staff and also practice placements (Health and Care Professions Council 2014a). Like the HCPC the CSP developed a separate document for supporting disabled students, which initially focused on support in clinical placements (Chartered Society of Physiotherapy 2004). In response to the Equality Act 2010 the CSP upgraded their advice to cover the whole of physiotherapy education from admission onwards. This is a comprehensive document which considers key concepts, including the Equality Act 2010, disclosure, competencies, reasonable adjustments to meet these competencies and inclusion. It provides guidance to academic staff, students and the clinical staff who support students on clinical placements.

Despite the comprehensive nature of these advice documents it is questionable whether they are accessed by disabled physiotherapy students or prospective students. They are both available on the websites of the respective organisations, but not necessarily obvious unless the person seeking the information is aware of the documents and tenacious enough to seek them out. It is arguable that many prospective disabled students considering physiotherapy

as a career have no knowledge of either the CSP or the HCPC, let alone the existence of these supportive documents. The research commissioned by the HCPC when revising 'A disabled person's guide to becoming a health professional' (Heath Professions Council 2006) found that very few of the health professional student participants had been aware of the document prior to reviewing it as part of that study (Clouder *et al.* 2013). Harrison *et al.* (2009:138) commented on the need to increase the accessibility of information for disabled students on university websites in general. Therefore this study incorporates a review of the internet to establish the availability of, and ease of locating, information for disabled students about physiotherapy as a prospective career.

3.7 Summary

This chapter has reviewed the existing situation for disabled therapists and students within the physiotherapy profession. It appears that physiotherapists share the attitudes of the general public towards disability and the professional culture maintains a corporeal image associated with a high level of physical capability, which is reinforced by the wording of the HCPC and CSP standards. This association may potentially create barriers for disabled people within the profession, especially if they are assumed to lack this physicality. The current research reporting the experiences of disabled health professionals suggests that disabled practitioners face barriers at each level of the SEAWall of discrimination (Swain, French, and Cameron 2003:2) (societal, institutional and individual): professional culture, fitness to practise policies, and attitudinal barriers.

The discussion of the physiotherapy profession and the education of physiotherapy students revealed two paradoxes which have a major impact on the integration of disabled students. Firstly, the expectation of a physiotherapist being physically capable is at odds with the general assumptions of disabled people. Secondly, physiotherapy academic personnel are required to be supportive of disabled students, yet to question their fitness to practise and to protect the standards of the profession. These issues are related as the attitudes of the staff towards disabled people will affect their willingness to consider the

potential of disabled students as being greater than the assumed risks to the profession. These are important issues to explore within this research, as Botham and Nicholson (2014:475) stated, this professional culture needs to be identified and addressed to facilitate change for disabled students.

This chapter has also served to identify the gaps within the literature about the integration of disabled students into the physiotherapy profession. The most important gap is the absence of the voice of disabled students. There is also no exploration of the discrepancy between the rhetoric of policy and the actual practices occurring in the process of educating physiotherapy students. Finally, there is little research into the accessibility of guidance information for potential disabled students. Consequently, this research started from the point of the disabled students' perspective, contrasting the wording of documentation and perceived availability of information with the experiences of the students. My study provided many unique contributions to knowledge by introducing the voices and experiences of disabled students and also will hopefully help to facilitate positive change to the system once the findings are disseminated.

Having identified gaps in the literature it is necessary to determine a theoretical perspective from which to research these issues. As Gable (2014) identified disability as a laminar system of complex characteristics any theoretical perspective must address these layers, whilst also providing tools to investigate the education of student physiotherapists in a critical manner. Chapter four introduces my ontological, epistemological and theoretical perspectives for this research.

Chapter Four: Exploring Disability

“Research without theory is blind and theory without research is empty”
(Bourdieu and Wacquant 1992:162).

4.1 Introduction

As acknowledged in chapter two, models of disability serve to describe the factors which contribute to disability, but they are not theories which assist in exploring these influences. Nevertheless, they help to identify that disability is a socially constructed concept dependent on multiple factors within both society and the individual. Therefore, in order to investigate the experience of disability, it is necessary to perform this from a perspective which considers all of the factors identified as contributing to the concept of disability. This chapter, and the following chapter, form the basis of a discussion of my research design. Here I discuss the ontological and epistemological basis of this research, aligning myself with a constructivist epistemology which links to both realist and relativist ontological paradigms.

Within constructivism there are a number of different theoretical perspectives which may be grouped into three broad categories; constructionism, structuralism and interpretivism. I briefly explore each of these groups, establishing that none of them are fully appropriate for this research as they are constructed on a dualism between structure and agency. The critical realist and ICF models of disability both consider the person and their psyche as having an involvement in the construction of disability, along with culture and social factors. Therefore I required a theoretical perspective that considers structure and agency in the construction of disability. Accordingly, I compare the works of Giddens and Bourdieu, establishing that Giddens’ Structuration is a more abstract theoretical conceptualisation, whilst Bourdieu’s Theory of Practice is a more pragmatic perspective for analysis of the multiple interactions within society. Consequently, I conclude the chapter by demonstrating that Bourdieu’s Theory of Practice is an appropriate theoretical perspective for analysing the complexity of disability, which can incorporate Gable’s (2014) framework of Critical Realism. I also

establish the interlinking of Bourdieu's theory of practice with social psychological theories of human behaviour and the SEAwall model of discrimination (Swain, French and Cameron 2003:2), demonstrating how an interweaving of these concepts will constitute my theoretical lens.

4.2 The Ontological and Epistemological Underpinnings of my Research

Ontology and epistemology are topics within philosophy, the former being concerned with reality, whilst the latter focuses on knowledge of that reality. As such they are intrinsically linked and cannot be separated; one being dependent on the other. Epistemological studies can be divided into three broad approaches, objectivism, subjectivism and constructivism (Crotty 1998:8-9); each of these being related to certain ontological perspectives.

Objectivism is the notion that all objects exist outside of the conscious mind and have an innate meaning. Therefore, a chair exists, even if no one is conscious of it. Knowledge of a chair is gained from studying it and finding its inherent meaning. This epistemological perspective is linked to the ontological idea of realism: objects exist in a real world independent of consciousness. Within the epistemology of research this leads to the concept of positivism and post-positivism. Positivism's main tenet is that information is posited or given and is therefore absolute. The scientific method is a search for certainty within an ordered world. This is based on laws which are discovered by study to create absolute truths. These can be subjected to verification; by definition or by experience. Verified information then becomes an accepted fact. A positivistic approach discovers the innate meaning of the object through study, it does not ascribe meaning. Based on this concept positivists claim true objectivity and the ability to separate facts from values. Post-positivism, based on hypothetico-deductive reasoning, requires that science is put forward as theories or hypotheses which are then tested extensively to prove them false. However, even if a theory withstands this testing it cannot be claimed to be absolute truth (Crotty 1998:19-33). On the contrary, it is argued that it is not possible to truly

separate facts from values in this way; research is not performed in a vacuum, but against the historical and cultural context of the institutions in which the research occurs. Consequently, it is impossible to achieve absolute truths or laws (Hall 1999:12). This is the basis of most criticism of the positivistic approach, even from within an objectivistic epistemology. In the context of my research, it is not concerned with the correlation or interdependence of variables, but with exploring the topic of disability and physiotherapy from multiple perspectives. As identified in table 2.2 empirical and post-positivistic research is aligned with the individual model of disability, and more specifically the medical model, where it is used to measure pathologies, impairments, and treatment approaches. This was therefore not appropriate for use within this study. Furthermore, the discussion in chapter two identifies that disability is constructed of both subjective and objective factors, which objectivism cannot adequately examine.

Subjectivism gives the opposing view to objectivism, suggesting that meanings are imposed onto objects by the consciousness of the observer. The object is passive in this process and the meaning is imported from dreams, archetypes, beliefs or values (Crotty 1998:9). Subjectivism links to ontological approaches such as anti-realism and idealism, which challenge realism either by denying existence or by rejecting the independence of existence from consciousness. This epistemology leads to theoretical approaches, such as post-structuralism, which claim that meanings are created and reproduced within cultural practices, creating systems or structures for that culture. Within post-structuralism there is no concept of the self as being a separate entity; self is affected by culture, values and beliefs. This will have an influence upon everything a person does and therefore, in research, the subject and their influences become the primary focus. Critiques of post-structuralism suggest that it is nihilistic in its extreme and that it ignores the potential of knowledge to be emancipatory (Hall 1999:13-14). Again, with reference to table 2.2, we see that culture is only one of the many factors involved in the production of disability and I have already argued that the experience of disability needs to be considered from both the individual and societal perspectives. Whilst some of the elements that contribute to disability may be subjective, impairments are real and objective.

Hall (1999:15) suggested a middle ground between objectivism and subjectivism creating a “meaningful social discourse”; this is constructivism.

Constructivism states that although objects may exist outside of the mind (realism) the meaning of these objects is created by an interaction of the object and consciousness of the observer (relativism). Knowledge is considered to be constructed between the objects existing in the world and the meanings which we impose onto these objects (Crotty 1998:44). This interaction will create multiple perspectives of the object, depending on the subjectivity (beliefs, values, culture, history etc) that the observer brings to the situation. Thus constructivism lies in the middle ground between the dichotomy of subjectivism and objectivism. This is the only epistemological approach in which both the subject and object are active. Within this paradigm it is impossible to discuss the object without reference to the person experiencing the phenomenon, and vice versa. It is also not possible to select true or false viewpoints, only those which are, or are not, useful.

My research sits firmly within the constructivist epistemology, and particularly social constructionism. My research aim is concerned with the access to the profession of physiotherapy for disabled students with the interactions between these two entities being the area to be explored by collecting data on the practices of the physiotherapy students in their everyday experiences of studying physiotherapy; an area that until now has remained uncharted. The importance of an historical and social context for this research have been emphasised in the preceding chapters of my thesis, and will continue to be considered throughout the discussion to follow. One critique that may be levelled at my choice of a constructivist epistemology is that it is only aligned to the social models of disability (table 2.2). However, my subsequent choice of a Bourdieusian theoretical perspective addresses this potential criticism.

4.3 Theoretical Perspectives

Theoretical perspectives are sited within an epistemological paradigm and create the philosophy for methodologies (Crotty 1998:66). Within constructivism each perspective has a different way of viewing and studying the world, yet they all have the same origin: the everyday practices of members of society (Flick 2004:88). Three broad groupings of these theories have been proposed (Flick, von Kardorff and Steinke 2004:5); constructionism, which considers the practices that construct reality; structuralism, which focuses on the influence of structures on the construction of meaning, and finally interpretivism, which considers the subjective meaning created by the individual.

Social constructionism considers that the social world is constructed by the everyday practices of people against a social and historical background. It is within every day practices that our engagement with the world occurs and where we create knowledge, society and also reality itself. However, the effects of society's rules and regulations internalised by the individual, result in a collective creation of knowledge and society by means of shared concepts such as language (Crotty 1998:52-5). Within this perspective a researcher is looking for multiple meanings of the phenomenon being studied and is also considering the viewpoints of the participants within the research. It allows for a dialogue between the phenomenon, the participants, the contexts and the researcher to find multiple interpretations (Cresswell 2007:21).

In contrast, structuralist approaches place great import on the influence of the structures within society in the construction of knowledge. Crotty (1998:196) claimed that Durkheim was the precursor for structuralist theoretical perspectives. He took a functional scientific approach to studying society, believing that society existed as a separate entity to the individuals who created it. He insisted that the behaviour of individuals could only be comprehended by an understanding of society, which is a bounded unit possessing characteristics that confer membership or exclusion. These characteristics are based on moral decisions

and therefore society is a moral entity based on moral or social facts. These facts represent the collective consciousness or culture of the society, being learnt when we are socialised into society by education. Society represents the interaction between individual and collective levels of social facts, which are external to and constraining of individuals limiting behaviour at a subconscious level (Hughes, Sharrock and Martin 2003:159).

Although I appreciate that the structure of society does have an influence on behaviour I do not feel that it is the sole controlling factor as suggested within social constructionism and structuralism. I feel that although individuals are influenced by the structure in which they live, they also possess agency, the ability to decide their own fate. This agency is also involved in creating society with its rules, regulations, social facts, and roles. When researching disability structuralist approaches only consider the cultural, political and economic factors that affect the individual (table 2.2). Whilst they acknowledge that structure influences behaviour, they do not provide a means of exploring the process of internalisation. In order to explore the construct of disability more deeply, I required a perspective that also considers the meanings that individuals create.

To this end I considered the interpretivist approaches based on the work of Weber who perceived social life as a constant struggle between people, creating competition. He identified status groups within the social structure; membership being restricted to people possessing specific acceptable characteristics (Hughes, Sharrock and Martin 2003:104-114). When exploring society, Weber emphasised the need to understand a person's behaviour rather than to explain it; to understand the meanings that the person is making about their world. He claims that this is achieved by studying and interpreting social interactions between people to establish a causal explanation of this behaviour (Crotty 1998:69). However, more modern interpretivist approaches have moved away from this positivistic perspective. Modern interpretivism is concerned with exploring the ways in which culture affects our understanding of the world, and

can be divided into three main theoretical approaches: symbolic interactionism, phenomenology and hermeneutics (Crotty 1998:71).

Symbolic interactionism is an uncritical approach which focuses on practical outcomes, based on the American philosophy of pragmatism. The actions and agency of people are central to this approach, with individuals being seen as conscious reflexive practitioners. Pragmatists consider social life to be underpinned linguistically, as a symbolic tool used by people to interact (Denzin 2004:81-2). Rather than conceptualising grand theories at an abstract level, symbolic interactionists focus on studying real people, in their real situations requiring that any theories are induced from the lived experiences of the people (Sharrock, Hughes and Martin 2003:151-2). Although this perspective focuses on a person's meaning-making it does acknowledge the effects of social structures on the person, with the individual's agency creating these structures in a reflexive interactive manner (Denzin 2004:82).

Phenomenology and Hermeneutics are similar approaches that span both theoretical perspectives and methodologies. The philosophical assumption within phenomenology is that it is possible to revisit the immediate experience of a phenomenon by exploring the meaning creation of the individual, which is a first order construct, described as their life-world (Hitzler and Eberle 2004:68- 9). In this respect the researcher's own life world is considered a potential source of bias, creating a second degree construct, hence the researcher is required to bracket their prior experience and assumptions to allow the first order construct of the subjects to be revealed (Crotty 1998:79). This bracketing process is claimed to make phenomenology an objective process, but it is seldom fully achieved, which is one of the main criticisms of phenomenology (Crotty 1998:83). Conversely, within Hermeneutics, it is not considered possible to regain a first degree understanding; any interpretation of a person's experience will always be of the second order as it takes place within a perspective of interpretation. Rather than attempting to bracket, the researcher is obliged to become a reflexive practitioner considering the effects of their own assumptions on their

interpretation of the data, which is considered in its relationship to the subject, object and interpretation and also the socio-historical context within which it is gathered (Soeffner 2004:95- 98). Analysis of the data requires an iterative, reflexive, cyclical process moving from the part to the whole and then returning to develop a deep understanding of the topic (Bentz and Shapiro 1998:107).

Whilst phenomenological or hermeneutic approaches were both appropriate for my research I was sceptical about the possibility of truly bracketing all prior assumptions and experience. I considered the reflexivity of hermeneutics to be more achievable, and it is also an approach that developed from the analysis of text and therefore could be used with the both the data collection from the participants within my study and also the documents that I intended to review. Although hermeneutics is an approach congruent to exploring the lived experience of the disabled physiotherapy students, whilst considering the socio-historical context, it does not help to explore the social factors which contribute to the construction of disability (table 2.2). As previously discussed my study required an approach that combines the effects of structure as well as considering the agency of the individual. Schatzki (1997:283) maintained this is achieved by practice theory approaches.

4.4 Practice Theory

Practice theories consider social life to be constructed by interrelated practices which are consequences of human actions. Thus both structure and agency are combined within these actions in a reflexive iterative process of creation one by the other. Two of the main proponents of these types of theories were Giddens and Bourdieu (Schatzki 1997:283) Both theorists shared a constructivist epistemology and based their works on the theories of Marx, Weber and Durkheim (Webb, Schirato and Danaher 2002:7&64), which allowed them to combine both the influence of structure on the individual alongside the agency of that person. Giddens claimed that structure and agency are faces of the same coin and therefore cannot be dissociated from each other (Haralambos and Holborn 2000:1065); whilst Bourdieu asserted that people express their agency

through a concept called habitus, which is the embodiment of structure (Bourdieu and Wacquant 1992:127). Giddens (1990:301-2) maintained that social systems are built upon rules and resources and replicated from social interactions in a context which creates meaning for the agents. A person possesses agency, or capacity to act, allowing the potential to create change, if they disregard the rules within the structure. This capability to “act otherwise” may produce change (Outhwaite 1990:64-5). Sewell (1992) argued that, although Giddens’ concept of the duality of structure **and** agency is a useful development away from the dominance of structure **over** agency [my emphasis], his theory suffers from “serious gaps and logical deficiencies” (Sewell 1992:5) He asserted that the dual nature of structure can “engender stasis” (Sewell 1992:13-4), a view supported by Archer (1990:76-7) who argued that structuration produces a cohesive, recursive society, suited for continuation rather than change. She stated that Giddens fails to suggest which conditions maintain or change structure or to differentiate between the effects of trivial or major actions and the changes these may create. Another criticism of structuration is that it is too abstract, lacking concreteness as a concept and therefore difficult to apply to empirical research (Stinchcombe 1990:47&56).

In contrast, Bourdieu’s Theory of Practice has been lauded as providing a theory which is the “most successful attempt to make sense of the relationship between objective social structures...and everyday practice” (Webb, Schirato and Danaher 2002:1). The practical nature of this theory was demonstrated by Bourdieu’s own applications of his approach to multiple diverse areas of research, showing the transposable nature of his theory (Wacquant 1992:4; Bourdieu and Wacquant 1992:77). It is also a theory that was in part developed within research into the education system, albeit within France (Bourdieu and Passeron 1977). However Bourdieu too has his critics; Sewell’s (1992) and Archer’s (1990) critiques of a system which is resistant to change were also levelled at Bourdieu. Dreyfus and Rabinow (1993:36) claimed that Bourdieu’s theory sometimes applies an objective analysis in places where an interpretive stance would be more appropriate; whilst practices can be objectively described social meaning needs to be interpreted. They suggested further theoretical

development is needed to consider the “meaning of human being”. A lack of meta-theoretical development was discussed by Calhoun (1993:62 & 64) arguing that whilst Bourdieu maintained the importance of constructing theory from concrete empirical data, at a meso level, rather than from abstract theorising at a macro level, this does not stop him from making generalisations within his work. He also suggested this lack of theorising introduces a vagueness and lack of clarity to Bourdieu’s concepts.

It has been suggested that some of the misunderstandings of Bourdieu’s work are due to the delay in translation into English, causing the publications to be released out of the original chronological order, thus fragmenting the logic of Bourdieu’s argument (Postone, LiPuma and Calhoun 1993:7). Thus situations arise when concepts developed by Bourdieu are subsequently erroneously applied as described by Atkinson (2011) in his critique of the terms institutional and family habitus. James (2015) asserted a similar analysis of types of educational research which execute superficial applications of Bourdieu’s theories, sometimes again due to a misinterpretation of the concepts concerned. Harker, Maher and Wilkes (1990:4) also highlighted the importance of utilising all of Bourdieu’s concepts together, which is often the source of difficulties or criticisms in the application of Bourdieu’s Theory of Practice: Sewell (1992) for example only considered the concept of habitus in his discussion of structure.

Notwithstanding the above critiques of Bourdieu’s theoretical approach, I selected it as a social lens for my research as during my extensive readings of epistemology and theoretical perspectives I was uncomfortable with the duality between structure and agency. Bourdieu offered me a means of transcending this situation to consider how both structure and agency influence social life. As discussed by Reay (2015:9) I too felt an affinity with the argument when reading Bourdieu’s writings. On reflection, my background of teaching psychological theories to undergraduate physiotherapy students helped me to envisage how Bourdieu’s theoretical concepts could function at the individual level. Interestingly, Schatzki (1997:288 & 290) argued that Bourdieu’s emphasis on

habitus working through a practical understanding is not supported empirically by the theory of practice at a micro level. In fact he maintains that it is impossible to support the practical understanding at all; actions are governed by more than just understanding, such as emotions. I refute this claim; in the following discussion of Bourdieu's theory of practice I will use social psychology theories to demonstrate how Bourdieu's theory, particularly the concept of habitus, can be applied at a micro level; an analysis that is also supported by Reay (2015) and Wagner and McLaughlin (2015). Interestingly, it would seem that Bourdieu supported this view, he stated that the division between sociology, social psychology and psychology is erroneous; society exists in both institutions and in the socialised body (Bourdieu 1993:15), thus the study of the workings of sociology is equivalent to the study of social psychology (Wacquant 1992:13; Widick 2004:196).

4.5 Bourdieu's Theory of Practice

Bourdieu recognised that the combination of structure and agency makes it difficult to categorise his approach; his recognition of structure positions him alongside the structuralist "Grand Theoreticians", whilst his empirical research aligns him to symbolic interactionists (Bourdieu and Wacquant 1992:113); consequently he gave his approach a label of "constructivist structuralism" or "structuralist constructivism" (Bourdieu 1990a:123). He claimed that one of his most important intentions for his work was to transcend the division between objectivism and subjectivism, demonstrating that these two concepts occur in a "dialectical relation" (Bourdieu 1990a:126). However, Bourdieu claimed that his work is not in the pattern of deep and obscure grand theory (Bourdieu and Wacquant 1992:122), nor the "minutiae of daily practices" (Bourdieu 1992:113) preferring his theory to be seen as concepts, based on the relations of forces, that have been developed from research, which he referred to as a "scientific habitus"; a scientific feel for the game (Bourdieu and Wacquant 1992:161).

Bourdieu, like Sewell (1992), conceptualised structure as possessing duality. Firstly, the objectivity of the first order, which is seen in the distribution

and acquisition of resources, property and values, and the objectivity of the second order, constructions of understanding by means of a system of classification, which are mental and physical social norms acting as templates for practice. This creates a society which contains two dimensions; relations of power and relations of meanings. Therefore when studying social organisations it is necessary to complete a double analysis; the first to observe the objective structure and the second to uncover the relations that people contribute to in the maintenance of a social existence. During these analyses the consciousness and cognition of the agents must also be considered as working in harmony with the social structures to construct reality (Wacquant 1992:7-15). In Bourdieu's own words this construction is seen in the "dialectic relations between the objective structures... and the structured dispositions within which those structures are actualised and which tend to reproduce them" (Bourdieu 1977:3).

This definition identifies the relationship between structure and agency. Nevertheless, Bourdieu wished to move beyond the robotic reproduction of action based on rules, as with materialism, reintroducing agency to allow the person to negotiate their practice. Thus he described agency as based on dispositions, which the person acquires through experience (Bourdieu 1990a:9), permitting everyday practices to occur with little conscious effort as they are all situations that have been encountered before (Bourdieu and Wacquant 1992:121). It might be claimed that Bourdieu's thesis in this instance was very similar to Durkheim's theory of social facts. However, whilst Durkheim regarded structure as objective and separate from the person, Bourdieu considered it to be a mental structure developed from the dispositions possessed by, and embodied within, the agent, in a similar way to Sewell's schema (1992).

Harker, Maher and Wilkes (1990:4) asserted that there are two main conceptual tools within Bourdieu's theory of practice: Field and Habitus. Bourdieu did not discuss society; instead he referred to multiple fields of social space where agents interact. Each field possesses its own values and principles which influence its members by forces which act on the agents creating conflict and

competition between them. Habitus resides in the agents as dispositions which frame the person's action, thus field and habitus are relational and function to create practice (Wacquant 1992:16-18). The symbiotic relationship of habitus and structure might be demonstrated by the analogy of a river (figure 4.1), which is based on the Kawa model (Iwama 2006) (see chapter five for a full explanation of this model).

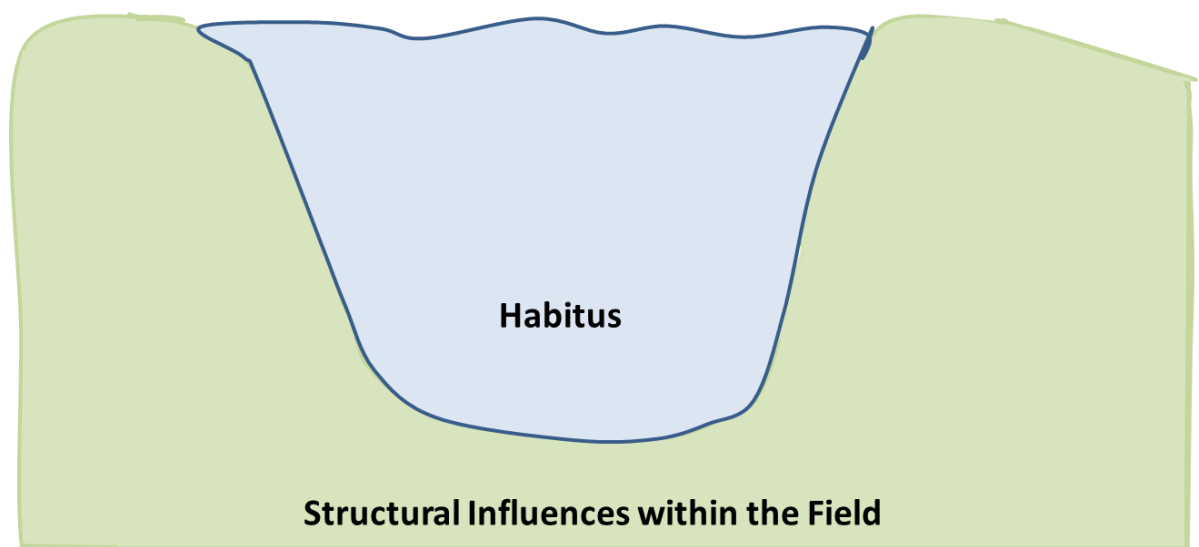


Figure 4.1: River Analogy of Bourdieu's Theory of Practice

The river represents the agent and its course is constrained by the structure of the ground [field] through which it flows, yet the force of the water within the river [habitus] contains the power to erode and deposit content, thus shaping the contours of the land in return. I will develop this model by adding concepts as I continue the discussion of Bourdieu's theory. Whilst Bourdieu's approach is about relations between habitus and field it is necessary firstly to define them separately before discussing the relationship between them.

4.5.1 Fields

Hage (2013b) declared that society is composed of multiple fields; fluid and dynamic social spaces which can interact with each other (Webb, Schirato and Danaher 2002:28). A field is not a geographical space, but a social space within which its forces are applied. The boundaries of any particular field are defined by the members of the field, as are the entrance criteria into the field and

both can only be established by empirical research. External influences do not act directly on agents, but are mediated through the field (Bourdieu and Wacquant 1992:100-5). Within any society there is a dominant field; the field of power, which is usually that occupied by the government or state and which controls the distribution of power throughout the other fields. Therefore the field of power could be considered as a meta-field, which during its development instigates structures, institutions and legal mechanisms to structure the population's perceptions and behaviours (Wacquant 1992:117). One of the key means used by this field to control power and to create structure is the use and legitimisation of language. (Webb, Schirato and Danaher 2002:86-96). Power is also maintained by doxa; the unquestioning acceptance, by the dominated, of their daily life world (Bourdieu and Wacquant 1992:73). The doxa within any field will establish the socially accepted behaviours and actions which serve to reinforce the structure of the field (Webb, Schirato and Danaher 2002:119). Most national cultures possess an overall doxa promoted by the government, using the media. This allows for ease of movement between fields within the national field as this doxa will apply to all of them (Webb, Schirato and Danaher 2002:42). Chapter two has described the overall doxa towards disabled people which is reproduced within British society.

Fields reproduce themselves by four processes (Webb, Schirato and Danaher 2002:25-27):

1. **Misrecognition:** accepting that the social world and associated norms are the natural order, rather than socially constructed.
2. **Symbolic Violence:** the dominant group within the field treat the dominated as inferior. The dominated are complicit in this situation as they misrecognise their treatment as the natural order.
3. **Illusio:** Each field possesses a specific illusio, which is the unthinking commitment of the members of the field to the logic and values of that field. The benefits of conforming to the norms of the field are greater than those gained by rebelling (Bourdieu and Wacquant 1992:115).
4. **Universalisation:** ensuring that all members of the field are required to accept the dominant group's values.

Bourdieu often used the analogy of sport when discussing the concept of fields and how they reproduce their structure (Harker, Maher and Wilkes 1990:7). He suggested that the doxa within the field is like the rules of the game and that the players have a vested interest in being wholly committed to these rules [illusio]. This commitment leads to the rules being accepted as the natural order and therefore axiomatic [misrecognition]. The dominant group within the field will use power and resources [symbolic violence] to suppress those judged as inferior and ensure that the values possessed by the dominant must be possessed by all [universalisation] in order to sustain and reproduce the field (Webb, Schirato and Danaher 2002:25-6). Bourdieu argued that within a society the rules of the game are formalised and codified by the bureaucratic departments (Bourdieu 1990a:80). Within my research the specific social field that affects the integration of disabled students is the field of physiotherapy education (Figure 3.1). As previously discussed this field is controlled by the government through the Department of Health and the Department of Business, Innovation and Skills. The HCPC and CSP develop policies and practices to regulate the field of physiotherapy education and one of my research aims was to establish the effects that these policies and practices have on the integration of disabled students into physiotherapy. Using a Bourdieusian lens to interrogate the data collected during this study, I was able to discover the processes that maintain and reproduce the status quo within physiotherapy education and how these processes influence the experiences of disabled students.

On returning to the river analogy, and considering the social construction of disability in the Field of Power, these concepts may be added as items which act upon the river (the disabled person) influencing its course (Figure 4.2). The anti-discriminatory laws have been passed in order to protect disabled people allowing their river to flow more freely. However, the general doxa towards disability, as previously described, is one of viewing disability as a tragedy and impairment as something to be feared. The concept of the corporeal standard is universally applied as are the neo-liberal ideals of productivity and independence. The agents within the field (the general public) accept this doxa with a total commitment to these aspirational values, misrecognising these values as the

natural order (illusio). The individual and medical models of disability are examples of symbolic violence against disabled people, often implemented by HCPs to maintain the dominance and power within the field. Bourdieu warned that misrecognition of distinctions made on objective difference such as race, gender and disability are very entrenched as they seem so obvious and natural (Webb, Schirato and Danaher 2002:83).

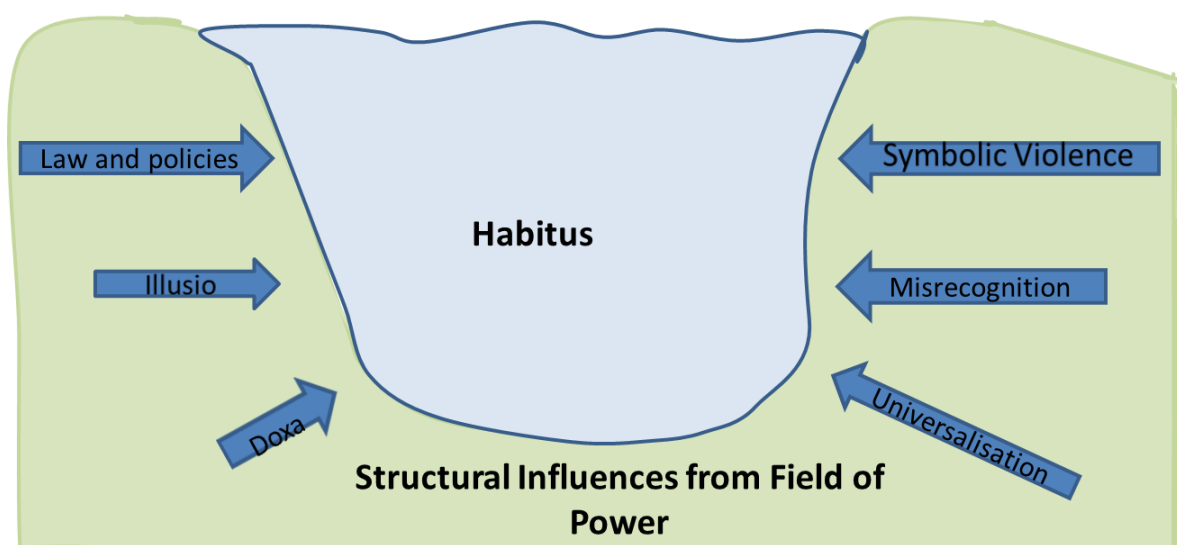


Figure 4.2: Development of River Analogy I

4.5.2 Habitus

As previously stated, habitus is the dispositions which frame a person's actions (Harker, Maher and Wilkes 1990:4). More exactly, habitus is enacted by a socialised body using structured dispositions (Bourdieu 1993:15). Bourdieu (1990a:9) suggested that these dispositions give the agent a "feel for the game"; a type of intuition as to the correct action or response in any situation, at any time: "Habitus is the durable and transposable systems of schemata or perceptions, appreciation and action that results from the institution of the social in the body" (Bourdieu and Wacquant 1992:127). Therefore it must be realised that the association between habitus and structure is not one of a circular iterative relationship (Bourdieu 1990a:118). Habitus is the structure internalised within the person, people embody these structural dispositions both physically and mentally in their movements and thought processes. A person's habitus includes all of the factors that determine their social relations. It embraces

personal attributes, background, behaviour and also the dispositions from societal structures. Once born into the field the developmental process integrates these societal structures into our dispositions through daily life influencing responses at an unconscious level (Widick 2004:227).

The development of habitus commences in the field of the family where the parents are the dominant parties acting as role models and prescribing the acceptability of actions (Bourdieu 1990a:91). When the child starts school they enter the field of education. For children raised within the middle classes this transition is smoother than for children from lower socio-economic classes; the dominant doxa within the field of education being that of the middle classes, thus these children already have a feel for the game. Consequently, we have the first point of intersection between two fields, that of the family and education. The child has to utilise the dispositions developed in the family field in this new environment, potentially with different values. This development of the habitus by the field is referred to as conditioning (Bourdieu and Wacquant 1992:127). Dissonance between field and habitus causes an adaptation of habitus towards the new field. Therefore, habitus is not a fixed constant; it is capable of adapting in response to new information. Accordingly, within my research, the student participants' socio-historical context was an important aspect to explore in the development of their habitus and aspirations to become a physiotherapist.

Within social psychology Social Representation Theory (figure 4.3) links strongly with this understanding of the development of habitus; social norms underpin shared beliefs which are very powerful and used to comprehend novel social experiences. Individuals are socialised into these beliefs from an early age, but have the capacity to amend their personal belief through the processes of assimilation or adaptation. Thus a person's belief system becomes an amalgamation of social ideology and personal beliefs, creating central unchanging tenets, but changeable justifications of these core beliefs, linking social ideology and individual cognition. In a new interaction a person will bring with them past experiences with which they compare the immediate situation in

order to process the new information and produce a decision (Hayes 2002:86-87).

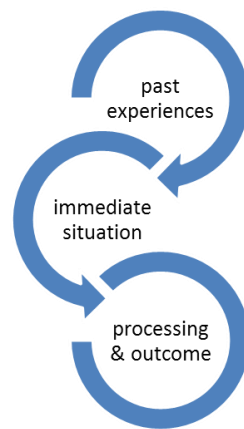


Figure 4.3: Social Representation Theory (Adapted from Hayes 2002:86)

With respect to disability, this central tenet seems to be that disability is a tragedy, while an impairment is something that is feared or even blamed (Riddell and Watson 2003:7-8).

Hage (2013a) emphasised the development possibility of habitus by explaining that it is a combination of our biological capability with the internalised ways of knowing how to interact socially. He elucidated that habitus is also creative, we do not just externalise all that we have internalised. We use our biological capability with our knowledge of the game in order to create an action. This understanding of habitus demonstrates the capacity for change from within the system, refuting the claim made by Sewell (1992) and Archer (1990) that Bourdieu's theory does not allow for change. Wagner and McLaughlin (2015:204) suggested that habitus is also composed of individual traits; whilst Reay (2015:10) asserted that it includes affective dispositions such as fatalism, rage, resilience and self-identity. The ability of habitus to undergo change may be explained by utilising the social psychological theories on individual self and the collective self.

4.5.2.1 Individual self

The self was once thought to be a single entity, but is now described as “a repertoire of relatively discrete and often quite varied identities” (Hogg and Vaughan 2011:122). Like habitus, these develop throughout our life-course constructed from the social interactions in which we engage. It is thought that we construct self-schemas in the same manner as schema are constructed to help process information about the behaviours of other people. We may possess multiple varied self-schemas, which are thought to offer the psyche a protective mechanism. Although a person will have a more complex identity if they possess a high number of schemas or schemas that are very specific. Self-Discrepancy Theory suggests that we have three types of self schema; ‘Actual’, who we are; ‘Ideal’, who we would like to be, or ‘Ought’, who we think we should be. Discrepancy between the actual and ideal or ought schemas drives behaviour to achieve these goals. Failure to gain our ideal schema results in disappointment, whereas failure to achieve our ought schema causes anxiety and fear. Alternatively, Social Comparison theory suggests that we compare ourselves to other people to seek validation of our attributes, values and behaviours. We tend to seek this validation from people who we consider similar to ourselves. However, if we are forced to make comparisons with people who we perceive to be superior, we feel devalued which decreases our self-esteem. People who possess low self-esteem lack certainty about their self-knowledge and have a self-protective orientation attempting to improve their limitations and avoid failure. Conversely, people with high self-esteem have a thorough self-knowledge with a self-advancing orientation; pursuing their goals to achieve success (Hogg and Vaughan 2011:118).

When considering how disabled people incorporate their impairment into their identity, Darling (2003) proposed a typology of disability orientation (table 4.1) in which he suggested that identity formation is based on the social norms and corporeal standard, and also depends on the person’s situation and personality. People who have access to the greater community and identify with those norms may display a normalisation approach; adjusting their concept of

normal to include their identity. Disabled people with access to the disabled subgroup, but who still identify with the majority norms will crusade until they have the resources which, at that moment, exclude them from the majority group.

Orientation	Majority Cultural Norms		Disability Subculture Norms	
	Access	Accept	Access	Accept
Normalisation	+	+	+/-	-
Crusadership	-	+	+	-
Affirmation	+/-	-	+	+
Situational Identification	+	+	+	+
Resignation	-	+	-	-
Apathy	+/-	-	+/-	-
Isolated Identification	-	-	-	+

Table 4.1: Orientation to disability (Darling 2003:885)

Once this access is achieved they normalise into the non-disabled group and cease their crusading activities. Disabled people with an affirmative identity may have access to the majority group, but reject those norms in favour of the disability subgroup identity and access. People who demonstrate situational identification have access to both groups of people and identity with each at different times or in different situations. Their identity may be expressed as fluid (Charmaz 2006:36). Whilst disabled people conforming to the majority norm, without access to either culture, may adopt a resignation attitude. A small number of disabled people who are completely uninformed may be presented as apathetic. The final group, isolated affirmers, may develop an affirmatory position to their situation in isolation from the disability subculture. However, this is highly unlikely (Darling 2003:889). Darling (2003:884) suggested that although there have been changes in society's attitudes towards disabled people over the past two decades with disabled activists encouraging an affirmative approach, many disabled people continue to adopt a normalised orientation. I propose that Darling (2003) has identified a difference between those disabled people with high or low

self-esteem. I maintain that people with a high self-esteem, who have greater self-knowledge and a positive self-image, would be more likely to have an affirmative orientation towards their disability, whilst people with a low self-esteem, who are attempting to reduce their limitations will adopt a normative orientation. As most disabled people are constantly comparing themselves unfavourably to the corporeal standard, they will have a negative self-esteem within their corporeal self-schema, encouraging them to adopt a normative orientation to try to reduce the discrepancy between their actual and ideal corporeal self. This incorporation of disability into self-identity is an aspect of habitus which may become apparent within the data analysis from the disabled student participants of my study.

4.5.2.2 Collective self

One means of achieving and maintaining high self-esteem is through group membership gaining a collective self-identity from the group, thus we have an individual self and a collective self when within our group (Hogg and Vaughan 2011:114). Interaction of individuals within groups and between groups creates group properties and understandings which affect the behaviours of the members of the group, both in the present situation and enduring over time to influence the behaviours of future generations. Social Identity Theory considers intergroup relationships from a social psychological perspective. It claims that there is a continuum from personal to social identity. Our own understanding of self is influenced by our membership within social groups. All social groups carry with them the potential for power and status. As individuals we are always seeking to belong to a group which will confer greater power and status. Therefore, we will act to improve or protect the power and status of the group to which we belong. One way of maintaining status is by comparison to a lower status group. In order to do this the group member acknowledges all the positive characteristic of people within their own group as being collective group attributes, whilst negative traits are seen as belonging to individual members. A high level of individuality is allowed within your own group to account for these differences. Conversely, the negative qualities of out-group members are seen to be typical of that group creating an outgroup homogeneity. This creates negative

attitudes towards other groups whilst increasing the status and self-esteem of the in-group members (Hayes 2002:89-92).

Social Identity Theory works by generating stereotypes of other groups of people, which are applied as a blanket description, creating homogeneity and losing the individual. This results in labelling groups with titles such as 'The Disabled': implying that all people with a disability are the same. Stereotypes are a natural way for humans to process vast amounts of information, but when they are directed at others in order to reinforce difference they can become the basis of prejudice. Prejudice in turn can lead to discrimination: treating people differently based on their membership of a social group. The relationship between stereotypes, prejudice and discrimination is complex, but all can be observed at an individual, institutional or cultural level and sometimes may be reinforced by law. Negative discrimination of a group is based on maintaining the superiority of the dominant group and the subjugation of the subjective group. Discrimination results in the everyday activities of individuals in the subjective group becoming limited (Whitley and Kite 2006:5-9). In order to avoid this discrimination a disabled person might choose to deny membership of that group by rejecting the label of disability, or strive to join a group of a higher status. One strategy for a disabled student to improve their status would be to join a professional group with a higher status, such as physiotherapy.

4.5.3 Practice

Bourdieu (1990a:62) argued that strategy is the concept that allows for agency and change within the system. Strategy is the product of habitus; the way in which the agent creatively uses their feel for the game. Bourdieu used habitus in a very practical sense, it is the knowledge of the practical sense of the field, giving the agent the ability to understand, negotiate, and anticipate the field. Strategies are "actions constructed in and through practice" (Bourdieu and Wacquant 1992:129). These allow the agent to make appropriate interactions within the field (Webb, Schirato, and Danaher 2002:49-50). An agent who possesses a high level of habitus will exhibit mastery within the field; they are constantly able to anticipate the correct moves necessary to maintain their

position (Bourdieu 1990a:61). This mastery demonstrates the creativity which Hage (2013a) discussed. Each person will have a different biological capability based on their genetic and psychological backgrounds. Thus each person has variable capabilities to combine with the socially constructed habitus to produce actions or strategies (Bourdieu 1990a:63). Another strategy available to agents within the field is the use of capital.

4.5.4 Capital

Capital may be seen as the third major concept in Bourdieu's theory and is defined as the "energy of social physics" (Bourdieu 1990b:122). There are three fundamental types of capital; economic, cultural and social. Economic capital is not just financial capital, but material possessions and resources that could contribute to increasing your financial status (Webb, Shirato and Danaher 2002:22). Social capital is based on your social contacts, it is the network of people who can support you in your aspirations: who you know, not what you know. Cultural capital, which Bourdieu suggested might be better referred to as informational capital, includes all the resources that confer status on a person. Bourdieu divided cultural capital into objectified: how to act, institutionalised: how to portray rights, and embodied: how to move (Bourdieu and Wacquant 1992:119). Hence people conditioned to a field possess the knowledge of how to belong within the field. For this reason, people who fortuitously acquire financial capital, which allows entry to a higher class, find it difficult to fit in as they do not possess the cultural capital of that field.

Each field will give different value to certain types of capital, which then become symbolic within that field and agents compete to possess this capital giving them an advantage within the field. Hence agents become competitive in their drive to acquire capital, particularly symbolic capital (Wacquant 1992:17). The struggle to amass and control capital provides the energy for the forces acting within the field. The members who possess the most capital, particularly cultural and symbolic capital hold the dominance within the field, which includes the ability to assign value to capital, denoting symbolic capital, which in turn controls the shape and structure of the field (Wacquant 1992:17-18). As

previously discussed, one method of maintaining the structure of the field is by symbolic violence. This is exerted by the dominant group onto the dominated group. This power is not exerted by submission, but by the misrecognition of the doxa being internalised into the dominated agents' habitus (Wacquant 1992:24). In this way the lower status people accept their position as the natural order and do not see any reason to think otherwise. This internalisation will therefore limit the strategies of the lower status people as their self-reflexivity will assert the mental structure that their position within the field is appropriate. Within my research the use of a Bourdieusian lens allows an analysis of the practices and policies of the field of physiotherapy, specifically to identify the means of reproduction of the field.

People possess capital in different forms and different amounts and this contributes to the strategies they will use during their negotiation for position within the field. Bourdieu again turned to a game analogy to explain the distribution and use of capital; a game of chance. He painted the scene of card players with the piles of tokens [capital] they have amassed to this point. Their tokens will differ in two ways, denomination [types of capital] and amount [volume of capital], with each player having a total volume of tokens. Each player's game strategy will differ based on the denomination and amount of tokens, but also on their 'feel for the game;' their understanding of the rules of the game [habitus] and their interpretation of their opponents play [strategy] (Bourdieu 1993:34). In this way a person's practice is the product of an interaction between their habitus, their capital and the field, which Bourdieu represented by the equation:

$$\text{Practice} = [(\text{habitus})(\text{capital})] + \text{field} \text{ (Harker, Mahar and Wilkes 1990:7).}$$

Bourdieu referred to all of the strategic actions which constitute practice as cultural literacy. This requires the agent to be self-reflexive; aware of their own resources and position in the field, which gives the agent a sense of their own limits (a sense of reality) (Bourdieu 1977:164). Having a greater knowledge of the field and higher volume of capital, particularly symbolic capital, will allow the agent more potential, and more ability to negotiate different situations within the field. While cultural literacy may accommodate a level of conscious processing,

Bourdieu reminded us that this is using the internalised dispositions from the field. Therefore what appear to be conscious decisions are rooted in the values of the field via the habitus (Webb, Schirato and Danaher 2002: 57-58), thus we are unable to think the unthinkable (Bourdieu and Wacquant 1992:40).

On returning to the river analogy (Figure 4.4), the struggle for position in the field, and the internalisation of misrecognition, are demonstrated as boulders; obstacles inhibiting the flow of the river. Capital, on the other hand, is represented as driftwood in the river flow, which can aid removal of obstacles or also become embedded restricting the river's flow to an even greater extent. For disabled people the strong misrecognition of the arbitrary division of people due to ability and inability limits their social interactions (Bourdieu 1977:164). It is also internalised into their habitus, creating an obstruction to their life course. The corporeal standard contains strong symbolic capital, which people with a visible impairment cannot possess. However, people with non-visible impairments can attempt to hide these in order to attune to this ideal body image and gain some symbolic capital.

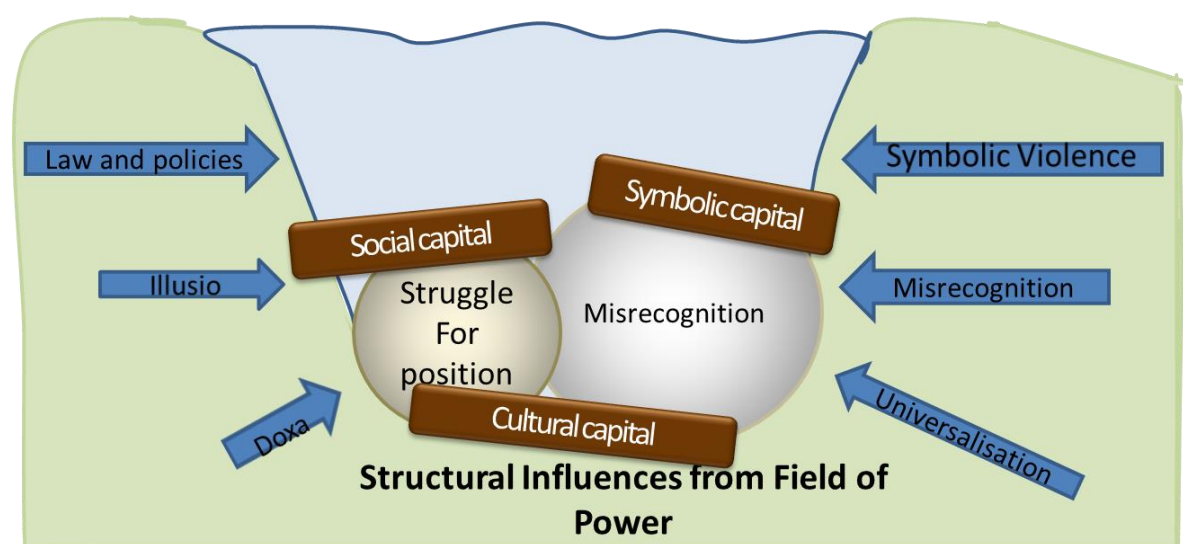


Figure 4.4: Final river analogy of Bourdieu's Theory of Practice

In the past the segregated school system limited a disabled person's cultural capital in two ways, the physical separation from the rest of the agents in the field, but also the lower academic expectations limited their access to

qualifications, which are another form of gaining cultural capital. Social capital may also be reduced as the doxa towards disability results in fear and avoidance limiting the social connections that disabled people can make. Thus all their capital is depicted as limiting their life chances or the flow of the river. This restriction of strategies causes a great struggle for the disabled person to position themselves within the field of power; which has been depicted as another hindrance to the river flow.

4.6 Selection of Theory of Practice as my Theoretical Perspective

Priestley (1998) constructed a typology of disability theory and research approaches which focus on the individual (subjective materialism or idealism) emphasising individual differences and experiences, or on the collective (objective materialism or idealism) emphasising a shared experience. He argued that each position is inadequate in isolation for studying disability, suggesting a more pluralistic approach (p.82). I maintain that this chapter has served to demonstrate that Bourdieu's theory of practice is just such a pluralist theoretical perspective and its use will encapsulate the general situation for disabled people, which I have elaborated in the previous chapters. It encompasses all of the layers stated in Gable's (2014) critical realist framework of disability and also the levels of discrimination identified in the SEAwall model of discrimination (Swain, French and Cameron 2003:2) (Table 4.2).

Epistemology	Models of disability		Layers of factors affecting disability	SEAwall Model of discrimination	Bourdieu's Theory of Practice	
Social Constructionism	Post-modern	Critical Realist/ICF	Cultural	Structural	Field	Practice
	Social		Political	Environmental		
			Economic			
	Social Relational		Psycho-social	Individual	Habitus	
Empiricist	Individual		Psychological			
			Biological			
			Chemical			
			Genetic			

Table 4.2: Mapping of Bourdieu's Theory of Practice against Gable's (2014) Critical Realist Framework

Practice occurs when the individual interacts with the field and it is this practice that helps to identify the field, its forces and boundaries (Harker, Maher and Wilkes 1990:15). Therefore, reviewing the practices of all individuals participating in this study, the students and the representatives from the HCPC and CSP, will help to disclose the field of physiotherapy education, the forces acting within it (including doxa and symbolic capital) and the implications of these for disabled physiotherapy students (research question three). Consideration of the field of physiotherapy education helps to explore the cultural, political and economic factors that affect the integration of disabled physiotherapy students (research question two), whilst studying the habitus of the students will help to identify the psycho-social, psychological and biological factors which will be different for each individual student (research question one).

Having identified Bourdieu's theory of practice as an appropriate theoretical perspective for this research, I conducted a literature search and established that, although Bourdieu's theories were used a lot in educational research, their use was limited in physiotherapy education. Öhman, Hägg and Dahlgren (1999) investigated the self-perceptions of academic tutors, whilst Mooney, Smythe and Jones (2008) conducted a study regarding tensions faced by clinical educators. Thus my research, using a Bourdieusian analysis from the perspective of disabled students, is unique and will contribute to knowledge in the field of physiotherapy education.

4.7 Summary

This chapter has served to document my examining of theoretical perspectives to justify my selection of a Bourdieusian analysis. Although my research is within the constructivist epistemology, the theories that only concerned structure were not adequate to investigate all of my research questions. Therefore I needed an approach which encompassed structure and agency. This led me to Giddens and Bourdieu. Whilst both of these approaches considered structure and agency, Bourdieu's Theory of Practice was developed from research and was a more practical approach to apply. It also maps well

against both Gable's (2014) critical realist framework of disability and Swain, French and Cameron's (2003) SEAwall model of discrimination. Bourdieu's refusal to be pigeon-holed into a particular research approach fits with my view of society; I too cannot espouse myself to an either or theorisation of social life.

Having established my ontological, epistemological and theoretical perspectives I then had to select a relevant methodological approach form my study. Within this approach appropriate methods for data collection and analysis were required. These are all discussed in chapter five.

Chapter 5: Methodology, Methods and Data Analysis.

“Creative arts is one lens through which to view the world; analytical/science is another. We see better with two lenses. We see best with both lenses focused and magnified”. (Richardson 2000:254)

5.1 Introduction

This chapter establishes the methodologies selected from within social constructionism for my research. Within the previous chapter I discussed my unease with polarised theoretical positions, and provided a rationale for selecting Bourdieu’s theory of practice as a theoretical perspective to transcend binary divisions. This chapter demonstrates the continuance of a search for a more blended approach to research. I commence by explaining the selection of crystallisation as a methodological framework which encompasses a pluralistic approach to research design to achieve a more holistic picture of the phenomenon of study, but also to ensure rigour of the research process.

The methodology I selected is called Mindful Inquiry (Bentz & Shapiro 1998), a specific approach which blends phenomenology, hermeneutics, and critical inquiry making it congruent with a crystallisation structure as it spans the qualitative field. An additional element in this methodology is the use of Buddhist principles towards the research process. Mindful Inquiry allows the combination of varied methods for data collection; I selected narrative inquiry, the Kawa model, semi-structured interviews, documentary analysis, systematic meta-synthesis, and survey tools to gather data from different aspects of the phenomenon. The use of these methods is explained incorporating the practicalities of the research process, such as the sampling techniques, participatory research, rigour and ethical considerations. Finally, I elaborate the data analysis process, which is based on Langdridge’s (2007) critical narrative analysis. This process involves six stages which are discussed in turn and related to the data analysis within this study.

5.2 Crystallisation

The concept of crystallisation developed within the post-modernist, particularly feminist, disillusionment with positivist methods within qualitative research. Crystallisation sits within social constructionism as it recognises that meanings, identities and even research methods are socially constructed refuting a fixed reality (Ellingson 2009:32). This approach argues that multiple methods from across the research continuum, preferably one from each area (see table 5.1), serve to provide a deeper more complex interpretation of the phenomenon to develop more ways of knowing (Ellingson 2009:10). Ellingson used the metaphor of using a crystal as a prism to view the different refractions of the light within them. The different forms of knowledge will reveal different aspects of the data which may have been missed using only one technique (Ellingson 2009:11). Each methodological genre illuminates a different facet of the topic, resulting in the research process identifying the findings as only a partial picture of the whole and establishing the social construction of the research process itself, including the positionality of the researcher and the transient nature of the knowledge it generates (Ellingson 2009:4). Hemming (2008) established that whilst the different methodologies create data that complement each other, they each generate exclusive data increasing the complexity of the findings, concluding that crystallisation does provide deeper knowledge of the phenomenon. Ellingson (2009:15-16) claimed that this is one of the strengths of crystallisation, allowing greater interconnections between experiences, generating a more nuanced analysis and representation of the phenomenon. Due to the critical element of the process, crystallisation offers a level of reflexive validity supporting the rigour of the research.

Nonetheless, Tobin and Begley (2004:394) questioned the feasibility of a crystallisation approach suggesting it is too complex and not necessarily any different to triangulation. The ability to be adept in different methodologies and forms of writing in a creative and reflective nature requires a level of skill that many researchers do not possess (Ellingson 2009:16-17). It may be argued that many researchers within health sciences have been socialised into a post-

positivistic paradigm; the adjustment from quantitative to qualitative research is a paradigm shift and to move further towards the creative end of the continuum is a bridge too far! Another limitation of crystallisation is that in gaining depth, breadth is often sacrificed, due to word constraints for texts. Therefore, authors have to make decisions for the focus of their writing in order to deliver multiple representations. Ellingson (2009:4) responded to criticisms of crystallisation by developing a framework to assist the researcher in applying its principles, which I utilised in my research design.

5.2.1 Crystallisation Framework

(Avis 2003):996) argued that the positivist epistemology of a single truth identifiable through research is no longer viable; hence all inquiry exists within one epistemological paradigm of pragmatism with all methodologies sharing the same epistemology. In contrast, Ellingson (2005:7) described a continuum of research with positivism at one end and subjectivism at the other. All methodologies are situated on the continuum between the two dichotomies, in three broad areas: realist/ scientific stance on the right, subjectivist/ artistic on the left and social constructionism occupying the middle ground (see Table 5.1). As indicated in the table there are no boundaries between each area and Ellingson (2009:5) recommended a blending of both scientific and artistic approaches by “selecting the genres that best support the truths in your research”; using more creative forms of representation of the data rather than the traditional qualitative approach which tends to replicate the technical language and definitive claims used in positivistic designs. Within my study the overall research aim was subdivided into research questions:

1. What are the lived experiences of disabled physiotherapy students?
 - a. what are the stories that can be told from the students' experiences?
 - b. what are the major events in these stories?
 - c. what meanings do the students make of their experiences?
2. How do the policies and practices within physiotherapy affect the integration of disabled students?
 - a. what are the underlying themes and contexts behind the policies and practices?

b. what meanings do representatives from the HCPC and CSP make of the policies?

3. What information is available to prospective disabled students considering physiotherapy as a career?

	Artistic/subjectivism →	Social Construction	← Scientific/realist
Goals	Unravel accepted truths. Construct personal truths. Make art. Explore the specific.	Construct situated knowledge. Generate description and understanding. Trouble the taken for granted.	Discover objective truth. Generalise to larger populations. Generate scientific knowledge.
Questions	How do we cope with life? What other ways can be imagined? How is my experience unique? 1a. What are the stories that can be told from the students' experiences? 1b. what are the major events in these stories?	How do people understand their experience? How do participants and researcher co-construct meaning? 1c. What meanings do the students make of their experiences? 2b. What meanings do representatives from the HCPC and CSP make of the policies?	What does it mean from the researcher's perspective? What is the relationship between factors? 3. What information is available for prospective students? 2a. What are the underlying themes and contexts behind the policies and practices?
Methodology	Artistic, Interpretive, inductive, personal, creativity, Aesthetics. Interpretive phenomenology. Ethnography.	Social constructionism, Inductive, emergent, Thick description. Co-creation of meaning. Phenomenology. Ethnography. Grounded Theory. Critical Theory.	Scientific, measurement, generalizability, theory testing Positivist, deductive
Methods	Interactive interviewing. Participant observation. Visual arts.	Semi-structured interviews. participant observation.	Coding textual data. Surveys Structured interviews. Frequencies.
Position of researcher	Researcher is main or equal focus	Participants are main focus, but researcher positioning is important	Researcher is presented as absent and objective
Quality Criteria	Do stories seem true? Are the findings coherent, plausible, aesthetically pleasing?	Flexibility. Openness and clarity of process. Clear, reasoned discussion with support and evidence of reflexivity	Authoritative rules. Need for reliability, validity and trustworthiness.

Table 5.1: Qualitative Research Continuum (After Ellingson 2009:8-9)
My research sub-questions are in red.

By mapping these research questions onto Ellingson's continuum (table 5.1 highlighted in red), I realised that my research aims fell into each of the three

areas and identified that in order to address these questions fully I would need to adopt the multi-genre approach advocated by Ellingson (2009).

5.2.2 Methodologies within the Continuum

The majority of the questions relating to this study fell within the subjectivist and social constructionism bandings which suggests that ethnography or interpretive phenomenology would be the most appropriate methodologies to select. Ethnography is the study of shared patterns of behaviour within a group culture by participant observation (Merriam 2014:28-9). However, as the participation occurs over an extended period the researcher often faces a tension of maintaining this objective detachment whilst participation develops an insider perspective (Luders 2004: 226). With respect to my research questions, ethnography was not practicable as the participants were distributed throughout England. Also, although people with impairments may share some disabling experiences, I did not want my research to reinforce the perception of disabled people as a homogenous group: 'the disabled'. My aim was to explore each person as an individual with different habitus, capital, and strategies.

In chapter four, I identified that phenomenology was a theoretical perspective and methodology consistent with exploring disability from the aspect of individual experience (question 1a, b, c, and 2b). It examines the response of the individual to "phenomena that present themselves immediately to us as conscious human beings" (Crotty 1998:78). As previously discussed, the researcher brackets their prior knowledge and experiences to introduce a level of objectivity and critique to the methodology (Crotty 1998:83). Nevertheless, the findings of phenomenological studies are analysed by the researcher using their own interpretation of the experiences of the participants, creating a second order construct (Bentz & Shapiro 1998:96). This intervention of the researcher is claimed as a limitation of phenomenology, as the views of the researcher may not necessarily be those of the participants. To address this, phenomenological researchers keep an audit trail to record the process of research and also use member checking to validate their understanding with the participants of the

study. However, member checking has also been criticised as challenging within a relativist constructivist epistemology (Tobin and Begley 2004:392).

A further limitation of phenomenology is the techniques of reducing the experiences of participants to a description of a shared essence, which again raises the potential of the homogenisation of the experience of disability. One methodology that moves beyond describing phenomenon is grounded theory. This methodology is quite positivistic in nature; although it starts with qualitative data the aim is to create a theory, grounded in the data (Goulding 2005: 296), which can be validated through further study to explain the original phenomena (Hildenbrand 2004: 22). Grounded theory was not appropriate for my study as it does not address the creative area of the continuum and I was not aiming to generate a theory on the ways in which disabled people are integrated into the physiotherapy profession. Again, this could create the idea of a homogenous group of people who all need approaching in exactly the same way. This could be repressive for disabled physiotherapy students in the future, which is contrary to my aims of conducting research that is both participatory and emancipatory.

One methodology that aims to be emancipatory and falls in the middle ground of the continuum is Critical Inquiry, which requires the researcher to have a critical view of the phenomenon seeking to understand and challenge the *status quo* by exposing the hidden power relationships that maintain society (Evans and King 2006:142). The full social and historical context of the phenomenon should be considered and the research question needs to be discussed as a concrete activity situated within this context rather than an abstract theorisation (Bentz & Shapiro 1998:147). The research should pose questions to the participants that require them to reflect on their situation and to solve the problems that confront them. Within this methodology is a need to review oppression, which is often very subtle and embedded within the values and assumptions of the group, with the aim to facilitate change for the benefit of the participants (Bentz & Shapiro 1998:146). Immanent critique is the process of focussing on the contradiction between ideology and the actual processes within an institution or organisation;

considering the paradoxes or contradictions between rhetoric and practice (Evans and King 2006:144). Usually, critical theorists are situated within the group, institution or culture that is being studied. This allows the researcher to identify with the norms and values that shape the organisation and allows a critique of the ideology. As a member of the group, the researcher will have a vested interest in the society and therefore the research cannot be classed as value or socially neutral. However, the researcher is required to be aware of their values and biases and to reflect on them (Bentz & Shapiro 1998: 149-150). As a physiotherapist I have been socialised into the profession and therefore share the norms and values that shape the phenomenon. This enabled me to use critical inquiry to explore the profession's response (question 2 a and b) to the integration of disabled students from an insider's perspective (see 5.3.1 for a more detailed description of my positionality).

Critical Inquiry tends to be conducted with other methodologies, and for my research combining it with interpretive phenomenology would include the creative and constructionist areas of the continuum. Regardless of the criticisms of phenomenology, it enabled the lived experiences of the disabled students and the perceptions of the CSP and HCPC representatives to be explored. Using an interpretive phenomenological approach does not aim to reduce experience to the essence, but to understand and interpret meaning from the participants' data (Benz and Shapiro 1998:96). Therefore I selected interpretive phenomenology to explore the students' experiences, using a narrative inquiry method for creativity, which considers the individual's life story focusing on telling the individual experience in an attempt to develop understanding of the topic (Cresswell 2007:78).

The two remaining questions (2a and 3) fell within the more positivistic area of the continuum. Question three requires measurement of the amount of information available for students and therefore a positivistic, deductive approach was appropriate using survey methodology to measure frequencies and record information (Crotty 1998:6). In contrast, the documentary analysis (question 2a)

of the policies required coding of the text and interpretation of the underlying themes. Hermeneutics, which is closely linked to phenomenology, is a process of generating meaning from texts. Within this methodology it is necessary to consider the historical and cultural context of the author(s) and also to consider the contemporary implication of the text (Bentz & Shapiro 1998:105). The phenomenon should be considered in its entirety in conjunction with sections; the meaning of the whole will have an impact on the understanding of parts and vice versa. In order to understand the phenomenon fully it is necessary to pursue an iterative process between data analysis and returning to the phenomenon allowing each repetition to deliver more understanding. This process is known as the hermeneutic circle, which is claimed to create a rich, deep understanding of data, within a cultural and historical context (Bentz & Shapiro 1998:110-112). When considering analysis it is important to realise that the meaning of a text is based on the semantics of the language used, the intent of the author(s)/speaker, the historical perspective, the relevance of the text to the reader/researcher and the reader's/researcher's interpretation. All of these factors will be influenced by both historical and cultural circumstances (Crotty 1998: 91). Thus hermeneutic inquiry is based on the interpretations of the researcher and therefore another researcher may create completely different meanings from the same text.

As a result for my study, a combination of interpretive phenomenology, hermeneutics and critical inquiry allowed a critique of the effects of the norms and assumptions of physiotherapy on the recruitment of students with impairments (question 2) and the interpretations and meaning making of the student participants within the narrative interviews (question 1), whilst a survey methodology collated data on the information available for students (question 3). Yet, Ellingson (2009:73) warned that pluralistic research design requires “balance between richness and diversity of perspective... and clarity”. Although she encouraged researchers to plan their design, setting out preliminary ideas and goals, she also urged them to remain open to innovation, allowing evolution of the process (Ellingson 2009:74). Bentz & Shapiro (1998:161) have developed Mindful Inquiry as a methodology that maintains an open mind by amalgamating hermeneutics, phenomenology and critical inquiry with the Buddhist tradition of

mindfulness. I adopted Mindful Inquiry for my study as it amalgamated the three methodologies that fulfilled the requirements of my research questions, covered each section of the crystallisation framework and also worked towards the aim of participatory and emancipatory research.

5.3 Mindful inquiry

Benz and Shapiro (1998), like Ellingson, advocated multiple perspectives for qualitative research, with the researcher at the centre making choices about research design. Mindful inquiry does not consider research to be neutral and objective; the combination of methodologies with a Buddhist philosophy connects the self-awareness of the researcher, including their moral and political values, with their research interests and the world in which the research occurs (Benz and Shapiro 1998:4). The authors developed the following criteria for Mindful Inquiry:

1. Self-awareness and an appreciation of how self and reality interact should be included in the research process. The self cannot be taken out of the research process as it is the researcher who identifies the epistemological underpinnings of their research and selects the theoretical frameworks, methodologies and methods for the data collection. Thus the researcher needs to be reflexive throughout the process, which is also advocated by Bourdieu (Wacquant 1992:36).
2. Integrating multiple perspectives enhances the research; a concept shared between Mindful Inquiry and crystallisation.
3. Assumptions should be bracketed allowing a search for the less obvious deeper levels of consciousness that underlie these assumptions.
4. Research is an ongoing process of interpreting oneself and others.
5. Research requires transcending above bias from both the researcher and the context.
6. We are always influenced by socio-historical and political factors, which introduce constraints, domination, oppression, and suffering.
7. Research involves compassion for the participants of your study.

8. Emancipatory research is an important goal and therefore research should critique the existing structures.
9. Critiques should encompass values, allusions and practices within the institutions involved.
10. Inquiry should develop the researcher's self-awareness, reflection and spirituality.
11. Although inquiry is grounded in self it may require the researcher to transcend themselves.
12. Inquiry may be part of social action.
13. The development of self-awareness is not only intellectual development, but a holistic development of self.

(Benz and Shapiro 1998:6-7).

The incorporation of Buddhism emphasises the requirement to increase self-awareness, and reduce suffering, whilst also confronting illusions such as false separations like the dichotomies between subjective and objective, structure and agency, mind and body (Benz and Shapiro 1998:38). Mindfulness is to live with intention from moment to moment (Kabat-Zinn 2013:5) which is combined with seeking to understand issues which pertain to self-improvement in thought and action, relationships with others, and in relating to the world that we inhabit and the wellbeing of the community (Erricker 2003:3;5). Consequently, Buddhism is a useful philosophy to assist in reflexivity during research, encouraging the researcher to remain open to the data, allowing findings to present themselves to their consciousness.

5.3.1 Mindful Inquiry Spiral

Benz and Shapiro (1998: 42-53) described the interpretive process as a mindful spiral moving forwards and expanding the exploration of the phenomenon, from an initial critical consideration, through phenomenology and hermeneutics to finish with a Buddhist interpretation of the research (Figure 5.1).

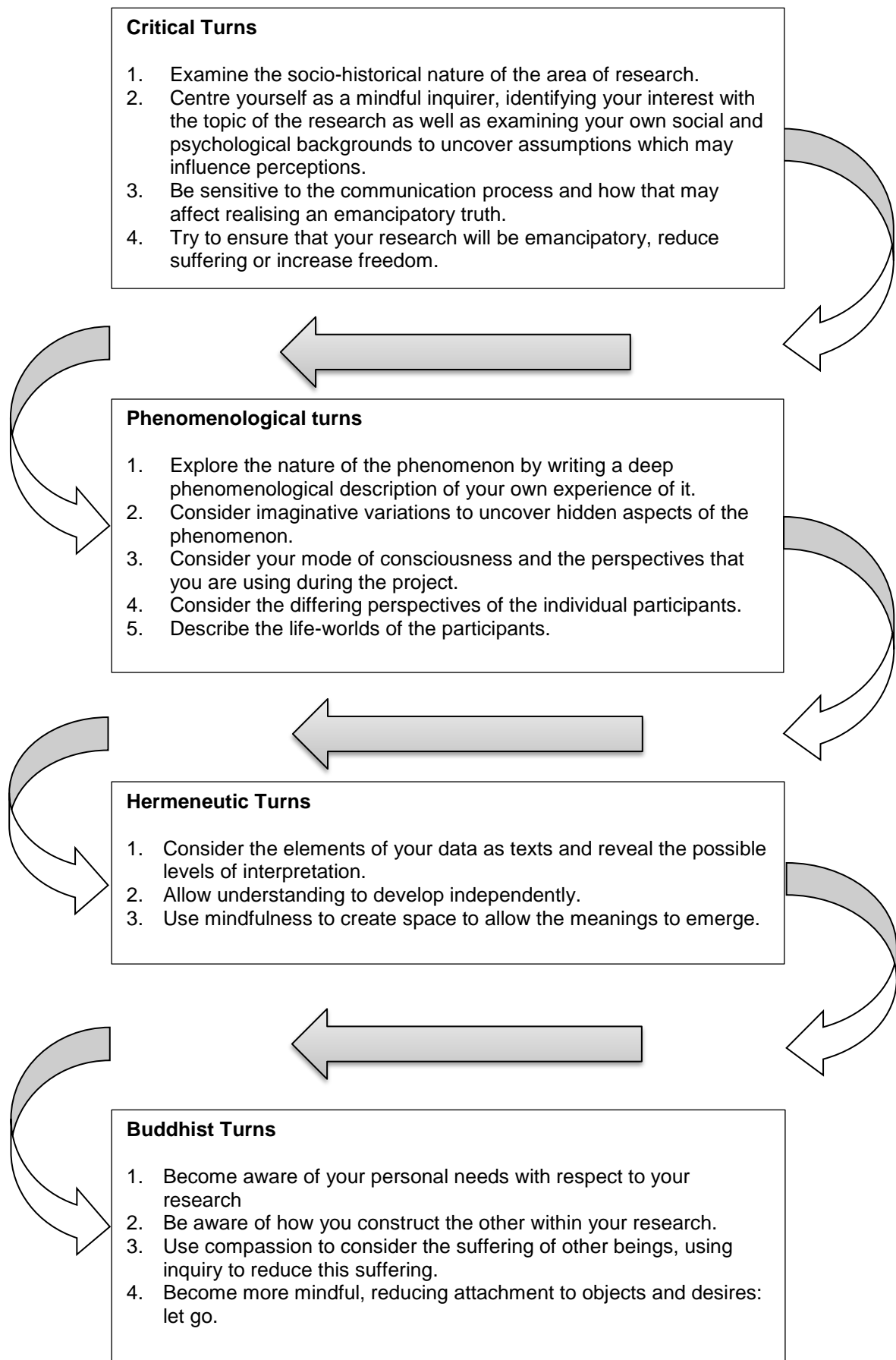


Figure 5.1: The Mindful Inquiry Spiral (After Bentz & Shapiro 1998:42-53)

They identified that all components of the spiral have equal importance, but that the researcher's path through the helix may deviate depending on the theoretical perspective they are utilising. Nevertheless, Benz and Shapiro (1998:43) highlighted specific turns within each section of the coil which they regard as essential, although they may be observed in a different order. I discuss these below, in the order denoted in figure 5.1 and with reference to my research.

5.3.1.1 Critical Turns

1. The socio-historical basis of this study is documented in chapters two and three.
2. My initial interest in the topic was stated in the introduction to this thesis. Here I consider my social background using Bourdieu's concepts of habitus and capital. My habitus has been developed through a strong extended family background, where I was encouraged to enjoy physical activity and sport. My Christian upbringing was, and still is, a highly influential aspect of my life. Christian teaching underpins my moral and spiritual values including a vocation towards helping others, striving to be compassionate and graceful in both thought and deed, and diligence within my professional life. With respect to disability, my assumptions are based on Jesus's compassion expressed in recorded meetings with people with impairments, although I do not subscribe to a charitable, pitying compassion, but one that seeks to enable.

My altruistic perspective is a form of cultural capital for working within the health professions. Similarly, as previously discussed, an enjoyment of physical activity and a diligent work ethos are valued within physiotherapy, and therefore may be seen as symbolic capital within this field. Bourdieu would argue that attending a private senior school provided me with the cultural capital to access higher education and a physiotherapy qualification. As already identified, I have worked as both a clinical and academic physiotherapist, which can be seen as either positive or negative. From the positive perspective, I possess experience within all the sectors of the physiotherapy field; from a negative perspective this means that I have been socialised into the values and assumptions of all aspects of physiotherapy.

Nevertheless this gives me the ability to critique both aspects of physiotherapy education.

Despite this insider position, Bourdieu warns that people who are long established within a field are the most likely to have a strong *illusio* towards it (Wacquant 1992:24). Reflecting on this claim, I do not consider myself to have this strong *illusio*, even though I have been a physiotherapist for twenty-nine years. Although physiotherapy is definitely part of my identity, I have other aspects of myself that take precedence: Christian, parent, wife, daughter, sister, friend are all important parts of my life, therefore physiotherapy is not my only path to fulfilment. Similarly, my most recent working life, within paediatrics and latterly higher education, has developed extended roles within my professional experience that have moved me away from the core aspects of physiotherapy. My administrative role as faculty disability coordinator requires me to ensure that disabled students are receiving their support packages and also to offer advice on disability issues throughout the faculty. In this situation I often challenge assumptions and discrimination, encouraging colleagues to be more open-minded about the potential for students with different impairments to be successful healthcare professionals. Despite acknowledging that this experience introduces a bias in my perspective towards my PhD research, I feel that this helped me to be more critical of the norms and values of the profession. I also consider that this learning support role helped to facilitate my interactions with the disabled students within this project, particularly those who volunteered from my university.

Furthermore, although I am a physiotherapist working in HE and share a concern about the future of the profession and the higher education system, I do not hold any authoritative role within the profession, and sometimes have a critical opinion of the ethos of the profession. Consequently, I may be the critical insider referred to within critical theory, being able to think the unthinkable (Wacquant 1992:40). Despite being a critical insider within physiotherapy and HE, and although I am left-handed - which some people suggest is limiting, with its own history of stigma and discrimination (Denny

and O'Sullivan 2007:4-5), I am not disabled, which might be seen as precluding me from carrying out disability research (see point 4).

3. My position as an academic physiotherapist might affect the communication between myself and the participants, creating a power differential between us, influencing their openness, particularly with students recruited from my university. As identified above, my role as learning support tutor may have helped to reduce the power differential between myself and students from my university, as they might have perceived me as an advocate who helped them with their negotiations for support. In order to facilitate the participants' truths I adopted a narrative inquiry method when interviewing the students which delivers the control of the interview to the participant (Holloway and Freshwater 2007:21). Another means of offering the participants more control was to allow them to select how they wished to contribute their information (see 5.4). The consideration of emphasising the students' truths was augmented by the adoption of a participatory approach to the research (see 5.5).
4. Within the field of disability studies there has been debate about non-disabled researchers carrying out disability research in the same way that people dispute men using a feminist theoretical position (Crotty 1998:161). Bricher (2000) argued that non-disabled researchers should not conduct research into disability as they may reinforce the medical model of disability and oppression. On the contrary, Kitchen (2000) suggested that a non-disabled researcher is valid providing that they consult disabled people during the research process, understanding that disabled people are an oppressed minority within the dominant non-disabled culture. Barnes (2014: 39-43) identified four characteristics of emancipatory disability research: accountability, social model of disability, data collection and empowerment. Accountability requires the researcher to be answerable to disabled people and organisations, whilst recognition of the social model entails ensuring that accounts of disability are situated within the acknowledgement of disabling environments and the general doxa of disability. Therefore, the researcher must consider their cultural competence when working with disabled people,

developing their empathy to attempt to consider the worldview of a disabled person. Data collection methodologies and methods must be suitable for the aims of the research with an explicit theoretical perspective. Finally, for the research to be empowering, it must generate data in an accessible form and have practical implications for disabled people. In this case it is important that the disabled people feel ownership of the research.

Within my studies the use of a participatory approach helped to develop ownership within the participants. I have acknowledged the social model of disability within the initial chapters of this thesis and within the data collection and analysis process by using a Bourdieusian theoretical perspective alongside reference to the SEAwall model of discrimination (Swain, French and Cameron 2003:2). The use of a crystallisation framework and Mindful Inquiry has served to elucidate the many factors involved in the construct of disability from multiple perspectives whilst maintaining the focus on outcomes which will improve the situation for disabled physiotherapy students. The iterative nature of the data collection developed deeper reflections by the students involved, facilitating enhanced self-awareness throughout the whole research process, which in itself is emancipatory.

5.3.1.2 Phenomenological Turns

1. During the project I kept an audit trail and project diary which allowed me to complete critical reflections and phenomenological descriptions of my experiences. I documented my frustrations, surprises, excitement and anxieties as I proceeded through this experience. This description of applying the Mindful Inquiry spiral to my research also functions as a phenomenological description of my experiences. Further reflection on the whole experience is incorporated into the conclusion chapter.
2. And 3. Imaginative variations are incorporated within the crystallisation process, by utilising methods that span the qualitative continuum. Thus using visual data collection methods (Kawa model), alongside narrative inquiry and survey methods, allowed me to observe the phenomenon from differing vantage points along with considering multiple meanings within

the findings. Similarly, within the data analysis, imaginative variations encouraged me to look at the data from both a Bourdieusian analysis as well as considering the impact of discrimination using the SEAwall model (Swain, French and Cameron 2003:2). Using Bourdieu's theory of practice allowed me to consider the participants' narratives at a deeper level, uncovering the social interactions within their stories and how these portrayed the strategies the students used to position themselves within the field of physiotherapy. The SEAwall model helped to expose barriers at structural, environmental and individual levels, demonstrating how these interacted and affected the integration of the disabled students.

- 4 and 5. The initial interview data were considered by the student participants in the second round of data collection (see methods section) and during the second stage of the data analysis (see critical narrative analysis section). The life world of all of the participants was considered using Bourdieu's concepts of habitus and capital. I consider the student voice to be the most important aspect of this research and their experiences underpin the whole of the findings chapters.

5.3.1.3 Hermeneutic Turns

- 1 All of the interview transcripts have been considered as texts within the data analysis process. Using critical narrative analysis (Langdridge 2007) each narrative has contributed to the exploration of the whole within the hermeneutic circle. The circle was developed into a spiral by introducing the data from the Kawa drawings and the second round of interviews. Further turns of the spiral encompassed the hermeneutic analysis of interviews with representatives of the CSP and HCPC alongside the documentary analysis of the policies of the physiotherapy profession. Finally, the systematic meta-synthesis data and survey data assisted in explaining the practices of the students within the physiotherapy field.
- 2 and 3. Using an iterative process of data collection and data analysis allowed space for ideas to develop, for example, the idea of students possessing multiple identities developed from an initial interview of one

student, which was then put to all the participants in the second round of data collection. I transcribed the interviews myself which facilitated a presence and immersion in the data creating the space for ideas to present themselves and develop. The staged approach within critical data analysis also served to create space and imaginative variation to enable alternative analyses to become exposed.

5.3.1.4 Buddhist Turns

1. This research is my doctoral programme, thus it contains a desire to demonstrate my ability to study at this level. I also hope that it is recognised as beneficial by members of the disability studies field as well as the physiotherapy profession and within HE. Yet above all of this my greatest desire is that this research will make a positive difference for disabled applicants in future years.
2. and 3. Throughout this process I have become much more aware of the construction of reality in general and disability specifically, realising that disability is a socially constructed concept rather than an objective reality. I have become very conscious of the use of language and terminology in the construction of 'other' and the oppression of disabled people. Throughout this thesis I have emphasised the social construction of disability as 'other', and represented disabled students in a positive manner. I am very conscious of the potential danger that some of my research findings might be used oppressively, attempting to minimise this risk by following a participatory process and using a Bourdieusian analysis to expose the strategies used by the dominant groups to maintain their hegemony.
4. Finally, I have learnt to let go. I always wished my study to be participatory and emancipatory and the involvement of the participants in the data analysis stages and the presentation of the initial findings at the CSP conference in 2014 (Opie *et al.* 2014) has helped to move this study beyond my PhD programme to a wider ownership. Further dissemination

of the findings of this project will also be participatory, including those participants who are willing to contribute.

As Mindful Inquiry blends hermeneutics, phenomenology and critical theory the methods associated with all of these methodologies were available for selection as research methods. Meanwhile, the addition of Buddhist principles expanded the potential to include methods with an Eastern origin. Within the above discussion I have already alluded to some of the methods employed within my research; the following section will explain all of the methods applied to the specific facets of the research agenda.

5.4 Methods

Following Cresswell's (2007: 108-9) recommendations the overarching research question was divided into sub-questions and topic questions to help identify appropriate methods for data collection (see table 5.2).

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Table 5.2: Research questions and selected methods (Cresswell 2007: 108-9)

Accordingly, the preferred methods for this study include narrative inquiry, the Kawa model and a qualitative systematic meta-synthesis to investigate the participants' experiences; semi-structured interviews and documentary analysis to explore the policies and practices of the profession, and survey methods to examine the information available to prospective students. As the experience of disabled students was central to this research, the data collection process began with the methods focused on disabled students. This then informed the other stages of data collection in the sequence indicated in the flow chart below (figure 5.2).

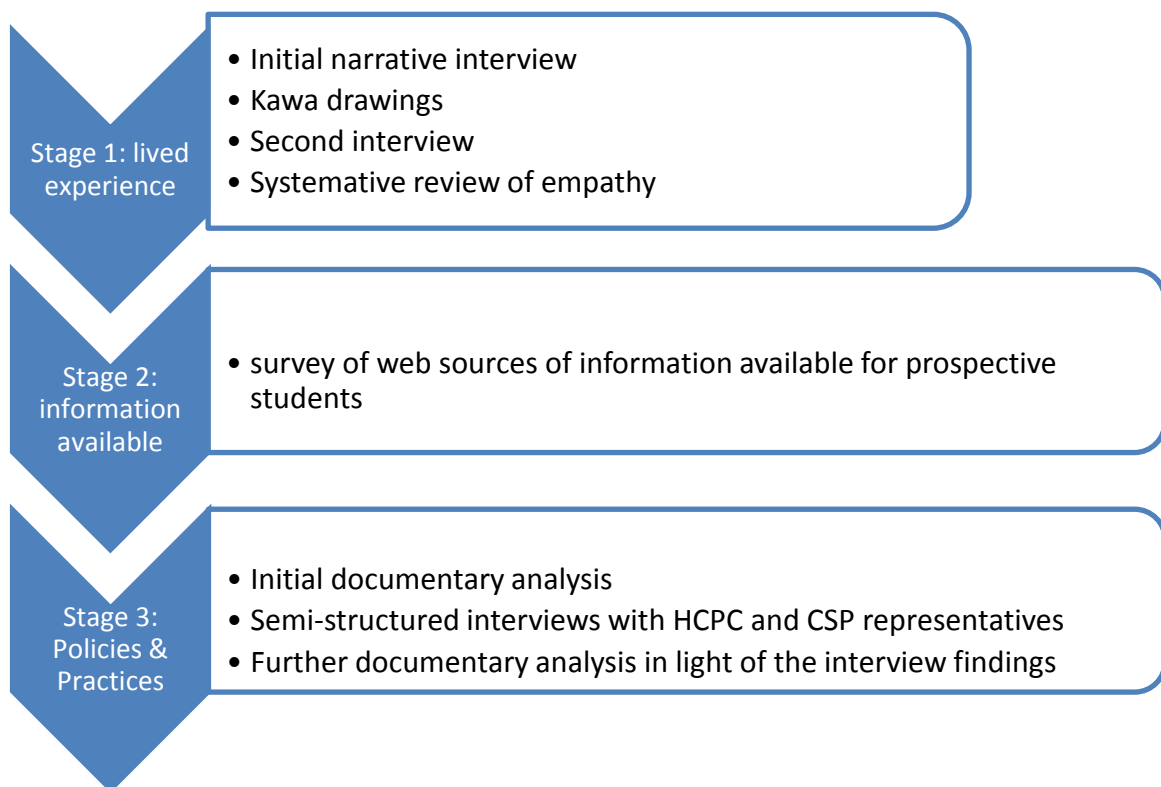


Figure 5.2: Flow diagram demonstrating ordering of methods utilised within this study

5.4.1 Ethical Considerations

Ellingson (2009:37) critiqued the limitations of the standard ethical considerations to the concepts of gaining consent and the avoidance of harm. Despite recognising the importance of these notions she suggested that they should be elaborated on within a crystallisation framework. The ethical researcher should destabilise the norm, avoiding reproducing the dominant

discourse by juxtaposing multiple accounts and truths. Their research should be used as a platform to provide opportunities for marginalised people to express themselves, thus facilitating social justice. Moreover, she recommended that the researcher should ask themselves if they are uneasy about any of the participants reviewing their analysis of the data (Ellingson 2009:41).

Within my research I gained ethical approval for interviewing the students and the representative of the organisations included (appendix A). Within the recruitment process I provided all participants with a participant pack including a covering letter, participation information sheet and informed consent sheet (appendix B) requested them to return a signed informed consent sheet if they wished to take part in the research. The use of Mindful Inquiry destabilised the norm, along with the use of a Bourdieusian analysis of the findings. The participatory nature facilitated multiple accounts and provided an opportunity for disabled students to express their reality. The Mindful spiral included a consideration of the political impact of this research within the critical and Buddhist turns, whilst the adoption of an emancipatory approach and Bourdieusian analysis resulted in recommendations which can increase social justice.

5.4.2 Emancipatory Research

As previously discussed (section 5.3.1.1) Barnes (2014: 39) highlighted the importance of accountability in achieving emancipatory research. Therefore before commencing any data collection I sought advice from disabled physiotherapists about the focus of this research. Prior to recruiting students I posted a message on the disability forum of the iCSP asking for assistance in the designing of the research, (Appendix C). I received replies from three disabled physiotherapists who, along with three disabled physiotherapists already known to me, informed me about issues that affected their particular impairment and helped me to formulate the prompt questions for the initial round of student interviews (appendix D). I also visited the Allied Health Professions Support Service in London, which offered a support service for disabled physiotherapists. I discussed my research with the managers there, gaining very helpful

information about the historical association of visual impairment and physiotherapy education.

5.4.3 Stage One: The lived Experience of Disabled Physiotherapy Students

Having established the shared experience of disability from my discussions with disabled physiotherapists and the Allied Health Professions Support Unit and having gained ethical approval from Coventry University Ethics Committee (appendix A), I was able to start recruiting students to my study.

5.4.3.1 Recruiting the Participants

The Critical Narrative Analysis (Langdridge 2007) approach to narrative research is very labour intensive and therefore participant numbers are often low and can be limited to a single case study. However, multiple participants will allow patterns in life stories to be identified when considering particular topics (Langdridge 2007:132). Considering this I followed a theoretical sampling technique as described by Silverman (2010:143-7). Theoretical sampling is more appropriate for qualitative research where the purpose is to relate findings to theory rather than populations. Thus participants are selected based on the settings, research focus, and the aims of transferability.

Within this study the setting has been specified as English universities due to the differences in legislation throughout Britain. Therefore, my sample selection was recruited from the forty-six undergraduate physiotherapy courses in England. The focus of my research is disability; thus students recruited had or had acquired impairments during their physiotherapy programme. In my role as learning support co-ordinator, I was aware that dyslexia was the most commonly represented impairment within the physiotherapy student cohort and that the ratio of female and male members of the physiotherapy profession is 4:1 (Health and Care Professions Council n.d); so my sample would probably reflect this by having a higher number of students with dyslexia and few male students. Theoretical sampling considers transferability of findings to theory rather than populations. Hence transferability may be achieved with just one case or participant, although a more structured research project often develops the

sampling during the iterative data collection and analysis process. This was the case with my research; the students being recruited over a two years period, which allowed a widening of the sample by introducing students with different impairments and including 'deviant' cases. 'Deviant' cases are those participants whose experiences do not support your argument or contrast with the experiences of the other students and are critical when testing theory and arguments (Silverman 2010:146).

The students within this research were recruited by two means. Firstly, I contacted the course director of each physiotherapy course, requesting them to distribute the participation information sheets and consent forms to disabled physiotherapy students on their pre-registration courses (Appendix E). This approach resulted in a sample size of six students. Secondly, I posted invitations for participants on the iCSP student and disability network pages, which increased the sample to ten students. This recruitment process resulted in students from different genders and age ranges, with different social backgrounds, entry qualifications and final destinations, and a spread of different impairments, although dyslexia is the most common condition.

Introducing the students

(Students were distributed between four HEIs in England. All of the names have been changed to protect confidentiality).

Helen

Helen has a visual impairment which developed in adulthood. She was a mature student living with her husband, local to the university. She possessed a chemistry degree and post-graduate teaching qualifications, having worked as a research chemist and primary school teacher. Unfortunately, due to numerous factors, she withdrew from her physiotherapy course during the first semester of year one.

Clare

Clare has a hearing impairment from childhood. She wears hearing aids to improve her hearing, which she augments with lip reading. Prior to attending university she lived at home with her parents and older sister. She selected a university some distance from her home, entering her course straight after completing her 'A' levels. She was in year one of her physiotherapy degree when recruited onto this study.

Alison

Alison also has a hearing impairment which developed in childhood. Likewise, she wears hearing aids supported by lip reading. She has four siblings and they all lived with her father when their parents divorced. She also entered her course straight from Sixth Form College and was in year one of her physiotherapy degree.

Sam

Sam has dyslexia, which was diagnosed in the transition to senior school. He grew up living with his brother and parents, although he commenced his physiotherapy degree after completing a sport science degree and working as a personal trainer. During his course he commuted to the university as he was living with his girlfriend. He was in year one of his physiotherapy course.

Jane

Jane has dyslexia, dyscalculia and dyspraxia, which were all diagnosed in her final year of study. She was a mature student with a previous equine science degree when she entered the physiotherapy course. She commuted to university, living at home with her parents. She was in her third year when she agreed to participate in this study.

Hannah

Hannah is dyslexic and also has juvenile chronic arthritis (JCA). She was diagnosed with dyslexia about age 7 and JCA at about age 15. Hannah's choice of university revolved around combining her athletics and studies, so she

selected university near to her training venue. She started straight from Sixth Form College and was in her second year of her physiotherapy course when joining this study.

Victoria

Victoria was a mature student in her second year at university, when recruited to this project. She has a history of mental wellbeing problems and had moved back in with her parents, so required a university within commutable distance of her parents' home. She has a previous degree in French and had worked for a number of years in accountancy.

Lauren

Lauren was a mature student and commuted to university from her home, which she shared with her husband. She was diagnosed initially with AD/HD and then with dyslexia during her second year. She had a previous sport science degree when she entered the physiotherapy course and had worked in retail and in the police force. She became a participant in this study when she was in her third year at university,

Sally

Sally has rheumatoid arthritis (RA). She was a mature student who also selected a university within a commutable distance of her parents' home where she was living. She had previously worked for a number of years in retail and then completed a sports therapy degree prior to commencing her physiotherapy course. She was in her first year of her physiotherapy course on becoming a participant in this study.

Jackie

Jackie was a mature student who entered her physiotherapy course after being a combat paramedic in the Armed Forces. She was in the second year of her physiotherapy course when she was involved in a motorcycle collision, causing her to become a permanent wheelchair user. Although Jackie wished to continue with her studies, the university she attended felt that this was not feasible and her place on her physiotherapy course was withdrawn.

All of the student participants, except for Helen and Jackie, successfully qualified as physiotherapists during the course of this project. Therefore, Helen and Jackie may be seen as 'deviant' cases, as they did not complete their courses, both withdrawing due to difficulties arising from their impairments (discussed in 7.9). Unfortunately, I was only able to recruit one male student thus the ratio of male to female participants did not mirror that of qualified physiotherapists as stated above. There may be many reasons for the lack of male recruits: non-disclosure of impairments, a more pragmatic approach to their course, a reluctance to reflect about their impairment or limited use of the iCSP, which was the more successful recruiting strategy external to my own university.

Once the students were recruited it was necessary to encourage them to contribute to the research over the duration of their course. I had intended to ask the students to keep a reflective diary throughout the course of the research. Instead, as the initial narrative interviews progressed, I became aware of the amount of extra effort that the students perceived themselves to be doing just to maintain their positions within their courses. Therefore, I readjusted my expectations of the amount of data and participation that the students would be able to provide during their course; two interviews and a Kawa drawing was requested from each student. Of the initial ten students recruited only eight completed a Kawa picture, as it was inappropriate for the students who had withdrawn from their courses. Seven participants reviewed each other's Kawa drawings and narrative summaries, which was the basis of the discussions within the second round of interviews; one student had graduated and did not reply to request emails. Participation within the thematic analysis of the interviews and Kawa pictures was limited to four students, all of whom were now qualified physiotherapists, who also helped to prepare and deliver a conference presentation to the CSP (Opie *et al.* 2014).

Even though participatory research is strongly favoured within disability studies (Barnes 2014:38) it is not easy to achieve. I found recruiting both qualified advisors and student participants difficult. The most successful means of

engaging interested parties was by a pre-existing personal relationship (seven students from my HEI) or through iCSP (3 students). This is understandable; as already discussed the students were working very hard to complete their degrees successfully. Even qualified disabled physiotherapists would still be maintaining a position within their local area of the field of physiotherapy, which again demands time and effort. Although all the people that responded to my initial requests discussed the merit of the research it was not a central concern for them, nor were they going to get any personal recompense for their participation, which may explain their limited involvement. Nevertheless, some advisers and participants, particularly those with whom I had a personal connection, were willing to contribute to a greater extent. Likewise, Block, Skeel and Keys (2006) found similar difficulties when conducting their participatory research. They recorded fifteen lessons they had learned from their project, divided into four areas: developing the partnership; gaining funding; implementation and dissemination. When developing the research community they endorse building on existing relationships, and relying on existing networks for recruitment strategies. This certainly seems to have been the case in my study.

5.4.3.2 Narrative Inquiry

As previously discussed (see 5.3.1.1), I was conscious of the potential power imbalance between the student participants and myself. I, therefore, chose to adopt methods from the creative end of the crystallisation continuum to gather data about the students' lived experiences. This included using a narrative inquiry method for the interviews, coupled with the unique use of the Kawa model as a pictorial representation of the students' life-course.

A narrative is our way of sharing our knowledge, allowing social interaction and a shared understanding of experiences. Narratives represent events and experiences (time) and the situations in which they occurred (space) in a meaningful way for the narrator using verbal phrases linked to those events (Elliott 2005: 6; Riessman 2007: 6). Therefore narrative research is consistent with Bourdieu's concern about situating data within its context. The plot is seen as the storyline that encapsulates the whole story, which is not always linear and

may be explicit or implicit (Elliott 2005: 6-7). Yet narrations are vulnerable; the narrator and listener need to ensure a shared understanding, otherwise the interpretations of the narrative may diverge. Despite this, a relativist epistemology recognises the potential for multiple interpretations, for example the listener may have a bias against accepting the story within the narrative as it may challenge their assumptions, whilst the narrator may use the narrative to justify their behaviour, or to protect credibility or self-esteem. These factors embed the sharing of a narrative within the present: the here and now (Rosenthal and Fischer-Rosenthal 2000: 259); framed within a specific culture and society (Holloway and Freshwater 2007: 9).

The move away from positivism towards interpretivism has created opportunities for the narrative approach, especially within the social sciences and health research (Parker and Wiltshire 2003: 97). Holloway and Freshwater (2007:3) identified narrative research as being positioned at the more unstructured end of the qualitative research spectrum, as they allow participants “to construct a version of reality in which they attribute cause, offer explanations and attempt to convince the hearer or reader of the plausibility of their version of events” (Taylor and White 2000:46). The researcher then interprets and identifies meaning, which is claimed to be the basis of the art or creativity found within narrative research (Holloway and Freshwater 2007:11).

Franits (2005: 577) recommended narratives as a good method for non-disabled therapists to gain a more complete understanding of their patients’ experiences and a better insider perspective of disability studies. As previously discussed narratives also equalised the communication differential between me and the students, giving them the control over the interview process. The literature exploring the experiences of disabled students and therapists previously discussed (chapters one and three) mainly utilised semi-structured interview techniques. Therefore, my use of narrative inquiry for this research was an innovative, imaginative approach (see 5.3.1.2). Despite this I needed a process to follow to facilitate these types of interviews, as I lacked previous experience

with this method of interviewing. One very structured seven stage procedure was developed by M^cAdams (1993), taking the participant through the interview by outlining their life as chapters in a book; giving a general introduction; highlighting specific events; talking about influential people in their life; making plans for the future; reflecting on stresses and problems; discussing their own ideologies and beliefs, and finally giving an overview of their own life theme. The resultant interview creates a summary of the whole life story of the participant, although it takes approximately two hours to complete. Langdrige (2007:133) argued that this is a very prescriptive approach, demanding for the participants and not necessarily appropriate when researching specific topics. Accordingly, not wanting to overburden the participants with protracted interviews or reflective writings, I adapted the framework to the specific topic of disability. Thus I asked each participant to imagine their life as an open book, with each life stage being represented by a chapter. Whilst considering their impairment I requested them to tell me about their journey to becoming a physiotherapy student, starting at the point they felt was most appropriate. To ensure that I gathered information on all of the topics suggested by the disabled physiotherapists who assisted in the preparatory stage I used a prompt sheet for myself (Appendix D), which was only referred to at the end of the student's narrative. The majority of these initial narrative interviews lasted between 45-60 minutes.

Although the usual method is an interview, narratives may also be collected in written form such as reflective writing and diaries (Langdrige 2007:132; Cresswell 2007:55). Hence I gave my participants a choice in documenting their experiences using an interview (either in person or via Skype) or by reflective writing. The same prompts were used in all formats. The student participants were free to select the method they preferred; seven chose interviews in person, one completed a telephone interview, whilst another was interviewed via digital media. The final student selected a written narrative as their preference. Offering this choice was consistent with the critical and phenomenological turns within the Mindful spiral, as it considered how the communication process affected the truth and it reflected the different perspectives of the participants, offering inclusivity for students whose

impairments limited their verbal communication. Another method I used to allow for inclusivity and creativity within the data collection process was the Kawa model.

5.4.3.3 The Kawa model

The Kawa model was developed within occupational therapy (OT) by a group of Japanese therapists who considered the existing OT models to be entrenched within a Western life-world and thus inappropriate for Eastern cultures (Iwama 2006:3; Lim and Iwama 2006:161). Iwama (2006:38-41) distinguished that the discrepancies between these cultures stem from the differences in the cosmological myths at the basis of each society. He explained that the East Asian Myth represents the universe as a single inseparable entity with no hierarchy or centrality: all the integral elements are interdependent and arranged within the collective. In contrast, Western society is based on monotheistic myths in which a single all-powerful deity is the holder of the Single Truth. This transcendence of a divine being introduces a hierarchical structure encouraging the concepts of independence and autonomy. Iwama (2006:20) clarified that the philosophical background for the Kawa model is social constructionism, as it upholds a pluralistic view of reality based on the Eastern cultures. Yet, it is claimed that the Kawa model gives a truly person centred approach, which is not culturally exclusive, and can be used with individual clients, groups or whole communities (Iwama 2006:223; Lim and Iwama 2006:184; Iwama, Thomson and MacDonald 2009:1134). Christiansen (2006:xii) predicted that the Kawa model will appeal to many people within the West as it is a holist model, combining mind and body within a dynamic metaphor of life experience.

The Kawa model is an emergent theory with limited literature describing its use, either as an OT rehabilitation model (Iwama 2006; Lim and Iwama 2007; Carmody *et al.* 2007), or as a research method (Nelson 2007). Much of the available literature is written or co-authored by one of the creators of the model, Michael Iwama, and therefore the bias of this author must be critically considered when reviewing the literature. Nevertheless, the corpus of knowledge

demonstrated that the model had been used within western cultures (Carmody *et al.* 2007) and also as a research method to help participants describe their life experiences (Nelson 2007). Carmody *et al.* (2007:226) concluded that using the Kawa model within a Western context “created both opportunities and challenges”. Participants expressed their own belief systems and values, describing and reflecting on their lives in context; although guiding the participants in how to construct their Kawa was identified as a challenge that could introduce the researcher’s preconceptions. Yet this research does show that, as a tool for reflection and consideration of the lived experience in context, the Kawa model has much to offer, even within a Western culture. Nelson’s (2007) research demonstrated that the Kawa model is appropriate to be used within a critical inquiry methodology to help participants reflect and generate data. Consequently, I was struck by how appropriate this model was for my study: its Eastern origin is compatible with Mindful Inquiry’s Buddhist principles; it is consistent with the creative part of the crystallisation continuum; it gave the students the opportunity for a deeper reflection of their situation, and an alternative, creative means of portraying these experiences. Therefore I chose to adopt this model as an original method of exploring the students’ life experiences.

The Kawa model uses the metaphor of nature to encourage people to consider their life journey as a river (Kawa is Japanese for river) flowing from its source (birth) to the ocean (death). Our life journey is prescribed by our environment, both physical and social, which constructs the riverbanks and bed. We also have problematic life circumstances that impede our life flow, which are represented by rocks lying in the river. Other factors, such as resources or capital, and attributes within our habitus, can also impact our life flow. These are represented as driftwood and can be assets that help us displace or erode rocks or they can be liabilities that get caught on the rocks and river banks augmenting the limitations created by the rocks. Within this model a person is encouraged to draw a cross section of their own life river at a specific place in time (Iwama 2006:130-134).

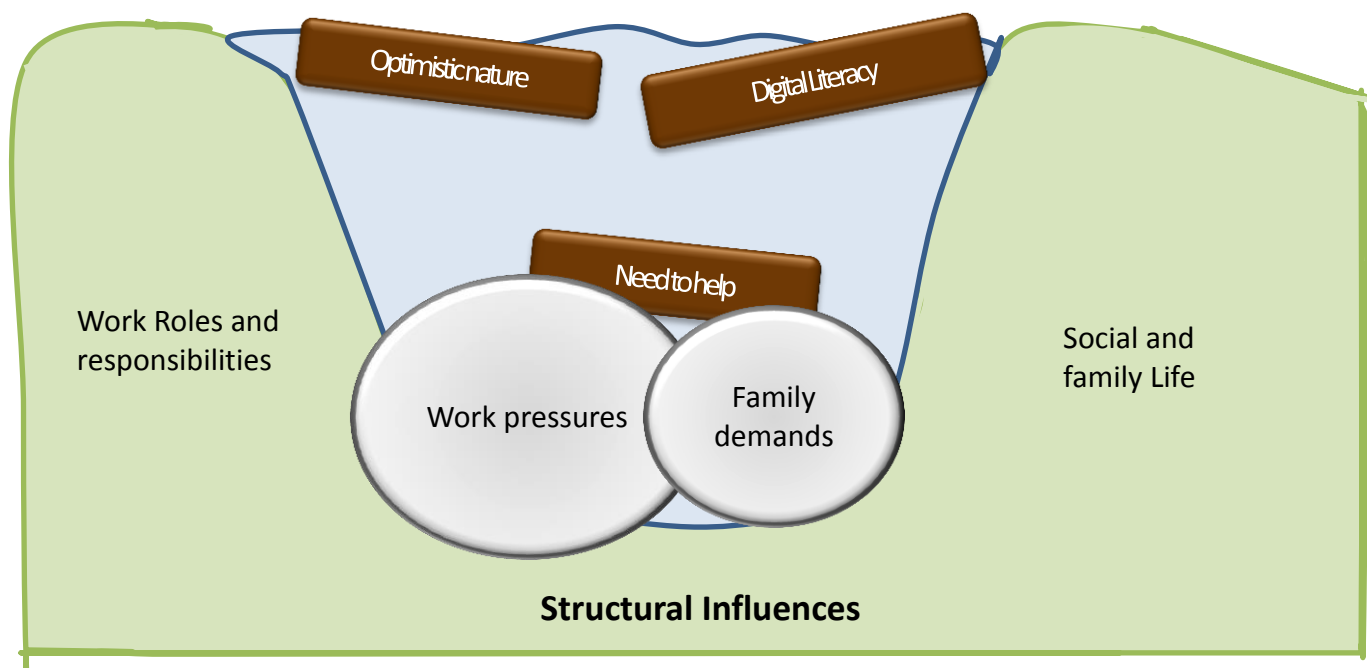


Figure 5.3: My PhD Kawa drawing

Figure 5.3 demonstrates a Kawa drawing completed during my PhD, with work pressures and family demands illustrated as impeding my PhD life forces in the area of the riverbanks which represent my work and family structural contexts. My optimistic nature and digital literacy are represented as driftwood that may remove obstacles, whilst my need to be helpful compounds both work pressures and home demands. Within this study the participants were given instructions about the Kawa model (Appendix F) and were encouraged to draw similar Kawa drawings which were then analysed alongside their oral or written narratives.

The initial narrative interviews were transcribed verbatim and a narrative summary was created (appendix G); both being checked by the relevant participant. Then the anonymised narrative summaries and Kawa pictures were distributed to all eight remaining participants asking them to review them for similarities or differences to their own situation. After this the students were interviewed again with new questions focusing on their responses to the shared narrative summaries and Kawa drawings, particularly concerning their perceptions of their own identity and how this related to disability (appendix H).

Again, these interviews were transcribed verbatim and reviewed by the participants (Appendix I).

5.4.3.4 Systematic meta-synthesis of empathy

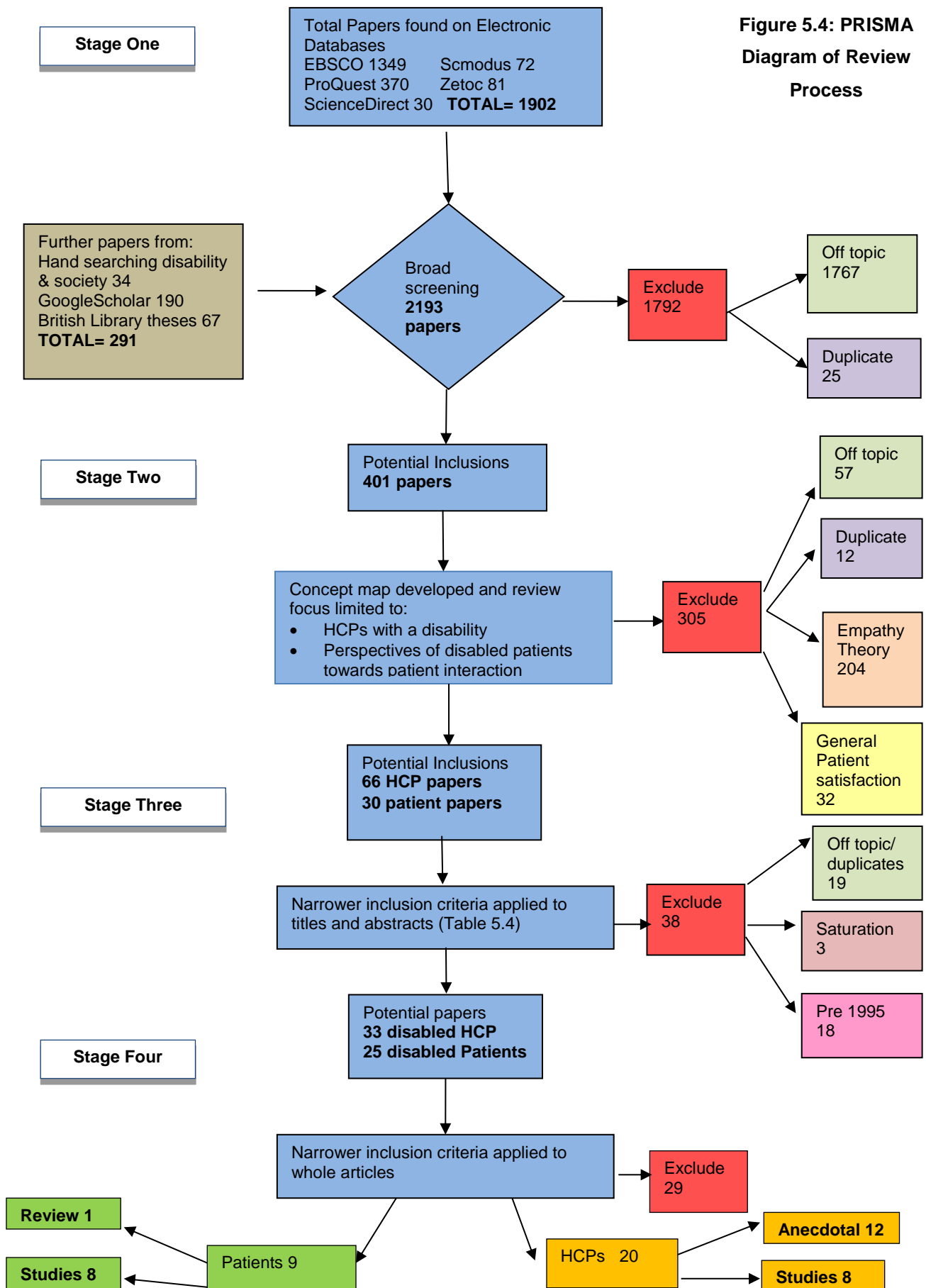
The focus of the methods to this point was to explore the students' reflections on their experiences and identity. Within this exploration a number of participants discussed an increased empathy with patients, which could be interpreted as a form of symbolic capital. The corpus of literature on disabled therapists also suggests that disabled health care professionals (HCPs) possess increased empathy (French 1988; Hargreaves *et al.* 2014; Taylor 2007). However these claims are made as adjuncts to the general discussion and unsubstantiated. From a Bourdieusian perspective they may be seen as misrecognition of the expected relationship between individuals with impairments rather than any actual interaction. Hence, I elected to conduct a systematic meta-synthesis of the literature seeking to examine the possibility of empathy as symbolic capital which gives disabled HCPs an advantage within the healthcare field. Nonetheless, I realised that the claims of increased empathy were being proposed from one perspective only; by HCPs with no corroboration from patients. Empathy should be a reciprocal experience that is also felt by the person receiving it: the patient. Accordingly, I reviewed papers discussing empathy from both the perspectives of disabled HCPs and disabled patients to achieve a more holistic overview of the experience, as consistent with the crystallisation framework of this research, within the scientific area of the continuum.

Booth (2012) recommended using the acronym SPICE to help formulate the review question and search strategy.

Setting	Patient Interaction
Perspective	Health Care Professional with disability
Interest	therapeutic relationship, empathy, patient satisfaction
Comparison	Patients with disability
Evaluation	Any research approach

Table 5.3: SPICE and Key terms for search strategy

**Figure 5.4: PRISMA
Diagram of Review
Process**



Therefore the question asked of the literature was:

“Do health care professionals with disabilities display greater empathy towards patients from the perspectives of both professionals and patients?”

Using the Prisma process (Figure 5.4) and the keywords identified in table 5.3 a broad search was conducted across numerous databases (Academic Search Complete, Ahmed, Medline Cinahl, PsychInfo, Assia, ScienceDirect, Scopus, the internet, GoogleScholar, the British library database of research theses) (see appendix J) , which revealed 2193 papers. The titles and abstracts of these papers were screened for relevance, reducing the number of articles to 401. Theoretical discussions of empathy or general patient satisfaction were then excluded, leaving 96 articles to be compared against narrower inclusion and exclusion criteria (Table 5.5), resulting in twenty-nine articles being included in the final quality appraisal (Appendix K) and synthesis stage (section 7.8.4).

Inclusion	Exclusion
English Language	Foreign languages
Peer review sources: journals and theses	Non-peer reviewed sources e.g. internet
Location: Western Europe, USA, Australasia	Other locations
HCPs with a disability or 'Impaired' HCPs: 1995 to present	Alcohol, Substance abuse or fitness to practice
Perceptions of patients with disabilities on therapeutic interactions or HCPs: 1995 to present	Validation of scales or tools or medication
Condition limiting to DDA included impairments	Acute conditions and Learning Disabilities
Only personal perspectives	Exclude parents, family or colleague reports
Topics: empathy or patient interaction	Other topics/focus

Table 5.4: Narrowing of inclusion criteria

The articles included for quality appraisal consisted of twenty papers concerning HCPs with a disability and nine studies on the perceptions of disabled people. These were all assessed for quality, although the data from all qualitative articles were included in the synthesis. As the search strategy found studies from both the quantitative and qualitative approaches the Critical Appraisal Skills Programme (CASP) (Public Health Resource Unit 2006) was used as it includes different frameworks for the different research designs. The tools used within this appraisal were the cohort study criteria, the qualitative research framework and

the systematic review tool. Appendix K demonstrates the application of the CASP tools in establishing the quality of the papers included in the review, whilst the following section documents the descriptive findings and the synthesis of the findings is explored in section 7.8.4.

Descriptive Findings of the Meta-synthesis

Disabled Health Professionals

One quantitative study investigated the effects of counsellor disability, and attending behaviour on the perceptions of disabled people. (Leierer *et al.* 1996). This study attempted to control all other variables, using a standardised rating form and statistical analysis to establish the linking between variables. This paper scored highly on the quality appraisal and was pertinent to the review question. Seven qualitative studies included HCPs with a disability as participants. Two of these articles focused on doctors and their disclosure to patients about their own health condition (Klitzman and Weiss 2006; Beach *et al.* 2004); whereas another considered how GPs' experiences of 'significant illness' affected their practice (Fox *et al.* 2009). Oliver (1995) explored the relationship between disabled counsellors and disabled clients; whilst French (1995) considered the experiences of physiotherapists with a visual impairment. The sixth article was an exploration of the experiences of disabled occupational therapists (Velde 2000), and finally Finlay (2003) conducted a phenomenological case analysis of a physiotherapist recently diagnosed with multiple sclerosis (MS). Velde (2000); Finlay (2003); Beach *et al.* (2004); and Fox *et al.* (2009) all scored well in the CASP appraisal, presenting a strong participant voice. Klitzman and Weiss (2006) had a weaker methodological approach whilst Oliver (1995) contained limited participant quotes. Finally, French (1995) had very limited discussion of the methodology and no discussion of ethical or rigour issues. However, it does include participants' words to develop the themes and to support the discussion.

Twelve anecdotal papers about different experiences of disability or a chronic health condition were also identified. These represented a cross section of HCPs and impairments and were included to increase the personal experience

of disability (Andrus 2007; Hilfiker 2001; Elmore 2011; Gaze 2003; Graham 2004; Maughan 2005; Smith 2003; Wells 2000; Brown 2011; Willett 1997; Weiss 2001; Lyall 2010).

Perceptions of Patients with Disabilities

There were nine papers in this section. One was a qualitative meta-synthesis of the experience of rehabilitation after spinal cord injury, which was found to be of high quality with a very well-reported process and findings that were highly relevant to this review (Whalley Hammell 2007). Roush (1995) conducted a quantitative investigation of the satisfaction levels of people with MS regarding rehabilitation services using the therapist evaluation form. This questionnaire was a development from a different tool, and whilst the original document had been tested for validity and reliability, the therapist version was still in the testing phase, reducing the reliability of the results of the study. The author claimed to have included open questions, but no participant quotes were published. Therefore, this article was excluded from the synthesis stage.

The qualitative articles included the expectations and preferences of patients with rheumatoid arthritis (Arthur and Clifford 2004); the experiences of an individual with a chronic condition being supported by a social worker with a similar condition (Lerner and Reid-Cunningham 2001); and the perceptions of health care from people with a brain injury (Darragh, Sample and Krieger 2001) and mental ill-health (Shattell *et al.* 2006; Shattell, Starr and Thomas 2007; O'Day *et al.* 2005). The final paper was a qualitative study of the perceptions of disabled people towards health professionals (Crisp 2000). Darragh, Sample and Kreiger (2001) and O'Day *et al.* (2005) scored highly on the CASP appraisal, covering rigour and credibility issues along with incorporating a strong participant voice. Lerner and Reid-Cunningham (2001); Arthur and Clifford (2004), and Shattell, Starr and Thomas (2007) had weaker methodological approaches, whilst Crisp (2000) and Shattell *et al.* (2006) incorporated limited participant quotes.

5.4.4 Stage Two: Advice available to prospective disabled students

This portion of the research project utilised an approach from the scientific, realist area of the crystallisation framework. As the research question posed a descriptive question: 'what?' it is best answered using a quantitative method (Sim and Wright 2000:19). Therefore a survey method was used to investigate the information available to prospective students. However, it was not appropriate for me to perform this survey as I was already aware of the location of information, for example the documents produced by the HCPC and CSP. Thus I involved two second year, undergraduate students studying an optional research module on non-health care courses to complete this survey. The students were identified by the administrator of the optional module, based on the students' expressed interests in research. I had also requested that disabled students on the module might be selected to participate in this research.

Non-physiotherapy students were recruited because they are in a similar position to prospective students; they may have a vague idea about what physiotherapy entails, but this will be at a superficial level. Hence this gave a more realistic replication of the situation of potential prospective disabled students. In fact, one of the two students had an impairment, which made the situation even more credible. The students were given minimal background information to aid them with their searching, as I did not want to influence their chosen search strategies. They were simply requested to imagine that they were a disabled student considering physiotherapy as a profession and to explore the internet to find any available information on the suitability of the profession for disabled people, including the support that may be available for disabled physiotherapy students. During their research they recorded the number of links they had to negotiate and the usefulness of the information they discovered (the findings of this survey are reported in section 7.9.1).

5.4.5 Stage Three: The policies and practices of the physiotherapy profession

The policies of the HCPC and CSP were reviewed using a hermeneutic documentary analysis, considering the effects of these policies on the integration

of disabled students. The standards of proficiency (Health and Care Professions Council 2013), of conduct, performance and ethics (Health and Care Professions Council 2012a), code of values and behaviours (Chartered Society of Physiotherapy 2011a) and QAA benchmarks (Quality Assurance Agency for Higher Education 2001) were all scrutinised. Initially the documentary analysis considered the socio-historical context of the documents (see section 3.4); the communication process within the policies, and the possible levels of interpretation of the documents. Although the policies of the HCPC, CSP or QAA did not display any explicit discriminatory language, the documents were further considered from an ableist perspective; identifying disablist language and scrutinised for potential alternative interpretations that may affect the integration of disabled students. For example, standards described using verbs associated with ability or performing a function were reviewed for the preciseness of the language and the potential for multiple interpretations of the meaning of the statements.

From an ableist perspective, many of the standards from each organisation use language which is associated with performance or practice, reinforcing the implicit tenet of physical ability within the profession. Similarly, this use of language may act as a barrier for the integration of disabled physiotherapists due to the way in which it is interpreted by people applying these standards to students. For example, standard 14 of the HCPC standards of proficiency requires therapists to be able to “deliver and evaluate physiotherapy programmes”. The verb deliver may be interpreted as an active process where the therapist performs activities with the patient, but equally it may also be interpreted as providing a physiotherapy programme which could be implemented by another individual.

Once this initial documentary analysis was completed and ethical approval was granted by Coventry University (appendix A), I approached the HCPC and the CSP to request representatives to participate in interviews (appendix L). The potential for interpretation of these policies with respect to disabled students was

discussed with representatives of both the HCPC and the CSP using semi-structured telephone interviews. Each interview lasted approximately one hour and included questions based on the initial documentary analysis and the findings from the previous two stages (disabled students' experiences and web survey) (Appendix M). The interviews were recorded, transcribed and checked for accuracy by the interviewees (appendix N). None of the people representing these organisations were actually physiotherapists. The HCPC contributors were from the policy unit and the administration of the physiotherapy register, whilst the CSP representatives were involved in the education and diversity departments.

Finally within the documentary analysis each standard specified by the HCPC, CSP and QAA was reviewed for its potential to create barriers for disabled students. Tables (Appendix O) were developed following a procedure performed by the Royal College of Veterinary Surgeons on essential competencies for newly qualified veterinary graduates (Tynan 2005). Within their project they considered each competency in turn, suggesting the potential negative or positive impact of that competency for students with specific impairments. I replicated this procedure with the HCPC standards of conduct, ethics and behaviour (table 1, Appendix O) and the HCPC standards of proficiency (table 2, Appendix O).

5.5 Rigour within this Research.

Within navigation the process of triangulation is used to identify the location of a fixed point from two existing known locations. This technique has been appropriated within research to describe the use of two different methods to increase the rigour of the research process and the validity or credibility of the findings (Kelle and Erzberger 2004: 174). Yet Kelle and Erzberger (2004:174) critiqued the use of a concept which suggests a single reality within qualitative research; triangulation is especially problematic within social constructionism, which considers reality to be socially constructed within relativist ontology. In contrast crystallisation, developed by Laurel Richardson, advocates the use of

multiple genres to explore phenomena as three dimensional crystal structures, which can be viewed from multiple perspectives (Tobin and Begley 2004:393). This pluralistic use of methodologies is also advocated by Wilson and Hutchinson (1991), Tobin and Begley (2004), (Annells 2006) and (Armour, Rivaux and Bell 2009) within health research when dealing with complex phenomena. Accordingly, crystallisation is more suited as a framework to ensure rigour of research situated within social constructionism than the post-positivist triangulation method.

Rigour refers to methodological thoroughness as well as ensuring the creditability of the research (Armour, Rivaux and Bell 2009). The use of a crystallisation framework has ensured methodological rigour within this research, combining approaches from across the qualitative continuum, by using the Mindful Inquiry methodology for the data collection and critical narrative analysis for the data analysis. The use of methods across the qualitative continuum served to emphasise the multiple perspectives on the integration of disabled students into the physiotherapy profession, in addition to exposing the areas where data, and thus knowledge is still deficient.

The criteria used to assess the quality of research findings are also contested (Armour, Rivaux and Bell 2009); Steinke 2004; Tobin and Begley 2004). Tobin and Begley (2004) discussed the importance of trustworthiness and goodness, which incorporate:

1. Credibility: the research represents the participants' experiences
2. Transferability: the ability to transfer the findings to other cases or to theory.
3. Dependability: there is adequate documentation of the research process.
4. Confirmability: the reality represented by the research is founded in the findings
5. Authenticity: the research displays a range of realities.

Nevertheless, these criteria have been criticised for being retrospective rather than during the research process (Tobin and Begley 2004:392). Armour,

Rivaux and Bell (2009:103) argued that predefined universal criteria like these are not suitable as quality assurance should develop from within the context of the methodology that has been selected. Despite this they recommended six guidelines developed from the constructivist paradigm (Armour, Rivaux and Bell 2009:118-119). By comparison Steinke (2004: 186-190) promoted six categories, whilst Richardson (2000:254) advocated five broad criteria. All three sources included relevance and reflexivity, indicating that these are considered highly important criteria, which fit within the assessment of credibility. I have used the preceding chapters to establish the relevance of my research design to the research questions, identifying the gaps in the literature, particularly the absence of disabled students' voices, and verifying the importance of my topic and the aspiration that it would not only contribute to knowledge but also be emancipatory for the participants and future physiotherapy students. Furthermore, the detailed documentation of the Mindful Inquiry spiral and the critical narrative analysis (Langdridge 2007: 134) incorporate reflexivity.

The dependability of my research is based on the precise record of the research process within the Mindful spiral, as recommended by Armour, Rivaux and Bell, and Steinke. This was also supported by audit trails and a research diary running throughout the length of the research, in which I noted necessary modifications during the research process. The use of a participatory research approach has facilitated the confirmability of the findings, as these were developed with the participants' assistance. This was enhanced by the use of participants' quotes within the findings chapters, as required by Richardson and Steinke. Finally, the authenticity of this study is supported by the comparison of the experiences of different students which demonstrates both convergent and divergent realities.

Richardson's criteria seem to be at a more theoretical level than the other guidelines. Thus she identified that research should be creative, inviting interpretation and creating an impact on the reader, which was hopefully achieved by my use of a crystallisation framework and an emancipatory, critical approach. The emancipatory approach also highlights the political implications of disability research (Barnes 2014:42), likewise Ellingson (2009:41) asserted that

ensuring that the research does not negatively impact on vulnerable groups, such as disabled people, is an ethical responsibility of the researcher.

5.6 Critical Narrative Analysis

Critical Narrative Analysis (CNA) is a staged approach to narrative analysis combining phenomenology, hermeneutics and critical inquiry and is therefore appropriate to utilise as a method of data analysis within a Mindful Inquiry methodology. Langdridge (2007:129) claimed that the most important component within the analysis is critiquing the text using social theory or theories, which in the case of this research were Bourdieu's theory of practice and the SEAwall model of discrimination. CNA incorporates six stages, which are used in a hermeneutic circle (figure 5.4). Although these are documented as separate stages they are not necessarily discrete. Stages 2-4 are the core of the analysis and are therefore crucial; stages 1 and 5 may be omitted in simplified versions, but it is these stages that introduce the critical element. Within this research the CNA analysis of the data occurred in an iterative process, moving between data collection and analysis during the stages.

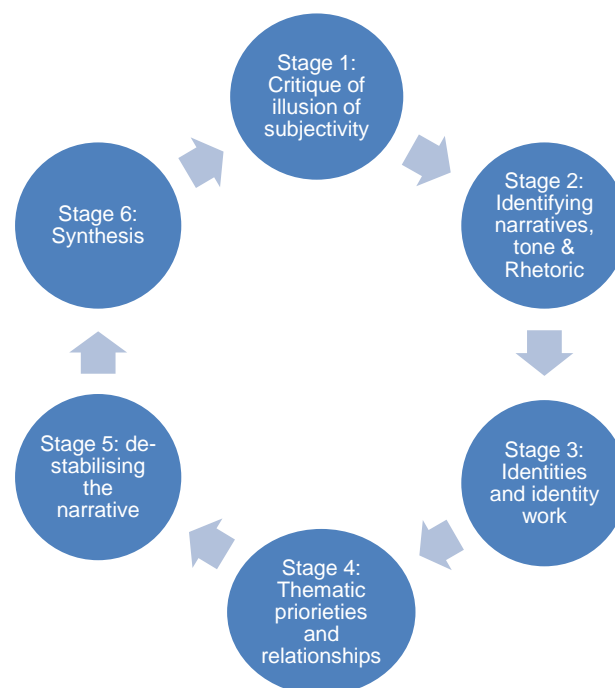


Figure 5.5: Critical Narrative Analysis (Adapted from Langdridge 2007:134)

5.6.1 Stage One: Critique of illusions of subjectivity

This initial stage considers the reflexivity of the researcher. In order to increase the critical level of reflection Langdridge (2007:134) suggests using at least one social theory framework or lens; I used Bourdieu's lens and considered my habitus, capital and my position in the field of physiotherapy (documented within phenomenological turns of the Mindful spiral).

5.6.2 Stage Two: Identifying Narratives, Tone and Rhetorical Function.

Each narrative was fully transcribed and a narrative summary was created giving an overview of each student's experience (appendix G); both were checked by the participant to ensure accuracy. Two of the student participants had withdrawn from their physiotherapy course so no further data was collected from them. The remaining eight students completed a Kawa picture (figure 5.6). The narrative summaries and Kawa pictures were anonymised and distributed to all students, with a request to reflect on the contents and to compare and contrast their own experiences with those of the other participants, facilitating a deeper reflection of their own experiences.

At this point, I analysed the transcripts and Kawa drawings to identify the stories and tone within them. Langdridge (2007:137) suggested that there may be more than one narrative within each transcript and that the tone of the narrative may vary throughout, which gives additional insight and reveals information that is not explicit within the text. The participant may also use explicit or implicit rhetorical features to make excuses, to justify their actions, or to criticise themselves or other characters within the narrative. The rhetoric and tone of the text will help to identify the function of the narrative. Within the participant narratives and Kawa pictures I identified four stories:

1. The interplay between the students' social and educational background and their impairment.
2. The story of their impairment.
3. The need for effort and determination.
4. Their aspiration to become a physiotherapist.

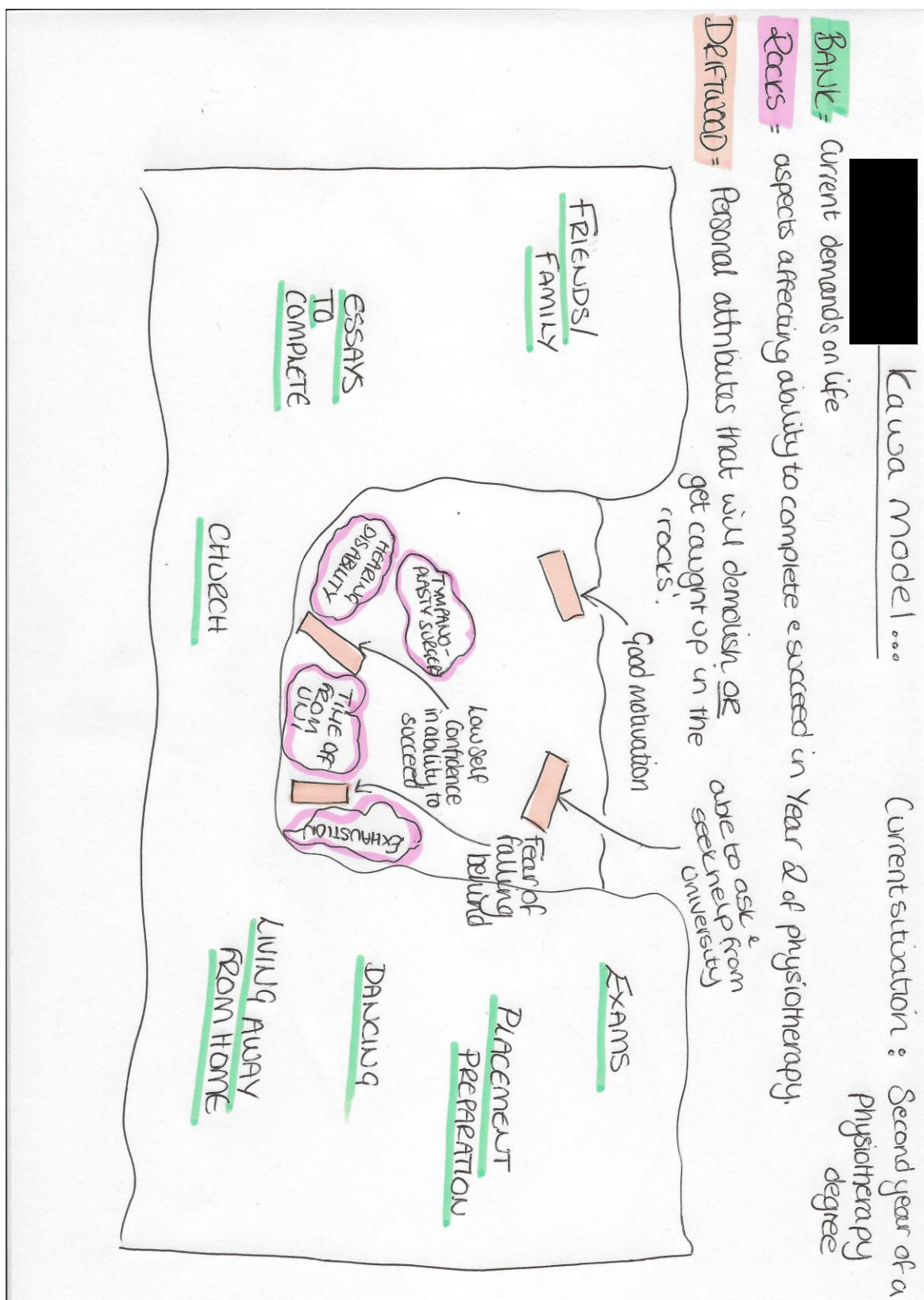


Figure 5.6: Clare's Kawa Drawing

The overall tone was mixed, one student was particularly positive whilst a number of students displayed embarrassment, frustration, a lack of self-confidence or anxiety, as represented in Clare's Kawa drawing (figure 5.6). Of the two students who withdrew from their courses, Helen was satisfied that her withdrawal was unavoidable, whilst the Jackie felt that unnecessary barriers had prevented her continuation on the course.

The overall tone of the HCPC and CSP documents is non-discriminatory towards disabled students and therapists. However, whilst these documents are not negative towards disabled practitioners, they fail to demonstrate a positive tone towards disabled physiotherapists. The representatives of both the HCPC and CSP portrayed a positive response to the idea of disabled physiotherapy students and expressed a shared understanding of a certain level of flexibility of interpretation of the HCPC and CSP policies.

5.6.3 Stage Three: Identities and identity work

Langdridge (2007: 138) recognised that the self is constructed and this stage concerns identifying how the participants constructed their self-identity. All of the participants possessed multi-faceted identities, with disability being only one aspect, if mentioned at all. Many of the students agreed that they possessed increased empathy with patients. This perception was supported by the findings of the systematic meta-synthesis, which found that disabled therapists possess emotive empathy, which non-disabled therapists lack (see 7.8.4.)

5.6.4 Stage Four: Thematic Priorities and Relationships.

This stage addressed the qualitative data analysis stage of identifying categories and themes within the data. The participants were invited to contribute to this thematic analysis, and four of them agreed (Sally, Victoria, Alison and Lauren). All of the interview transcripts, including those from the representatives from the HCPC and CSP, were distributed between the four co-researchers, requesting them to identify categories within the data (Appendix P). Langdridge (2007:138) encouraged looking for categories without breaking the text down too much, as this loses the overall sense of meaning of the narrative. The students

were instructed to review each transcript systematically highlighting key phrases or sentences and noting possible categories in the margins. Meanwhile, I thematically analysed all of the interview transcripts using the NVivo software package (QSR 2011). Then, these categories were reviewed across all of the transcripts for potential themes. Once each researcher had completed their analysis, I grouped the categories into themes and shared these with the team to seek agreement (Appendix Q).

5.6.5 Stage Five: Destabilising the narrative.

This stage was the critical analysis of the data using a social lens, in this case Bourdieu's theory of practice and the SEAwall model of discrimination. This required a sound understanding of both theories, which was not practicable to share with the other participants at this point, as they were all embarking on the commencement of their physiotherapy careers. Therefore, from this stage onwards I continued the analysis alone. The social theory lenses allowed all of the data gathered to be critiqued in order to facilitate an understanding of the construct of disability from multiple perspectives. Langdrige (2007:139) warned that the lens of critique is directed at the text only, it is important that it does not diminish the participant's experiences or emotions. Thus the agreed collaborative themes from the student interviews were reviewed through a Bourdieusian lens creating an overarching thematic analysis using Bourdieu's key concepts of habitus, capital and field. Similarly, the documentary analysis and interviews by the representatives of the HCPC and CSP were returned to as these identified the practices within the field, highlighting incidences of misrecognition, illusio, symbolic violence and discrimination.

5.6.6 Stage Six: Synthesis

Within the synthesis stage Langdrige (2007:140) emphasised the importance of giving prominence to the key narratives and participants' voices, ensuring that the participants are not represented as being less important than the social theory used to critique the narratives. I have endeavoured to do this within the findings chapters by using participant quotes as the basis of each section of analysis and by highlighting the participants' comments using italic font.

Ellingson (2009:59) challenged researchers using the crystallisation framework to present their findings in a more creative manner than the standard research report. She suggested that authors might produce an integrated quilted text where the standard structure incorporates sections of creativity alongside more traditional forms (Ellingson 2009:98). I have attempted to follow this structure, starting with a narrative chapter juxtaposing the experiences of two students who present with the same medical condition and similar backgrounds yet have developed a different habitus (chapter six). Chapter seven, Practices within the field, incorporates a pictorial metaphor of the effort that disabled students expend completing their courses. Finally, the Fields chapter (chapter eight) has a more traditional structure incorporating an overall Kawa representation of the field of physiotherapy as constructed from the data within this thesis.

5.7 Summary

This chapter has provided a detailed explanation of my methodological approach, choice of methods for data collection, and data analysis. The crystallisation framework and Mindful Inquiry have been demonstrated to sit within a constructivist epistemology. Using these two approaches has not been done before within physiotherapy and, therefore, this study will contribute to widening the methodological approaches available for research into physiotherapy. The combining of phenomenology, hermeneutics and critical inquiry with Buddhist principles of openness and mindfulness allowed for the selection of methods from across the qualitative continuum. The methods selected were appropriate for answering the research questions, but also introduced some creativity (crystallisation) and imaginative variation (Mindful Inquiry) offering differing perspectives of the phenomenon. The Kawa model offered an alternative means for the students to consider their experiences. This method of data collection is new to physiotherapy and also a development of the the Kawa model itself. Thus my research will contribute to increasing the knowledge of data collection methods available for qualitative methodologies.

Reflexivity is an important part of assessing the trustworthiness of research, and this has been demonstrated throughout this chapter. The dependability and authenticity of the research have been established by the use of a participatory approach. The process of data collection was divided into three stages: stage one exploring the lived experience of the disable student participants; stage two investigating the availability of information for students, and stage three examining the policies and practices within the field of physiotherapy. The analysis section presented an overview of the process of critical narrative analysis along with some of the descriptive findings. The subsequent chapters will present the findings of the critical analysis using the social lenses of Bourdieu's theory of practice and the SEAwall model of discrimination.

Within this thesis, the synthesis stage is presented in the following three findings chapters (6,7, and 8) and the discussion chapter (9). The findings chapters are arranged within Bourdieu's three concepts of habitus, practice and field. These concepts and, consequently, chapters are presented in the aforementioned order, because habitus is the embodiment of structure and thus determines the practice that agents use to position themselves within the field. Bourdieu and Wacquant (1992:100) argued that the boundaries of the field only become illuminated upon studying the practices of the agents within that field.

Chapter Six: The Development of Habitus, Capital and Strategies: Factors that Combine to Create the Students' Stance towards Disability

“what lies behind us and what lies before us are tiny matters compared to what lies within us” (Henry S. Haskins 1940:131)

6.1 Introduction

This chapter explores the background of two individual students from the study: Clare and Alison. These students have been chosen because, although they both have the same medical condition: Otitis Media (O.M) (glue ear), they approach their condition and the subsequent experience of disability from differing perspectives. Clare is embarrassed by her impairment and adopts a normalisation approach to disability, whilst Alison acknowledges her disability and has an affirmative approach towards it (Darling 2003 see 4.5.2.1). This chapter examines each student's life narrative to endeavour to understand the genesis of this difference. Using a Bourdieusian lens during the critical narrative analysis of the students' interviews I was able to explore the interactions between factors within the structure (society) and habitus (individual) of these two students and to propose suggestions as to how these students developed their different approaches.

Bourdieu explained that habitus is “social made body” (Bourdieu and Wacquant 1992:127). It embraces the dispositions from societal structures which we imbibe and integrate into our responses at an unconscious level along with our personal attributes. Consequently, this chapter begins by considering the social structures that influenced the students' development during childhood, an important stage for the development of habitus, particularly considering two fields, the family unit and school. Subsequently, the discussion moves to an examination of the students' internalisations of these influences into their habitus and how this reacts with their biological aspects to create their individual habitus (Hage 2013a).

Habitus drives our actions and is informed by them in an iterative process (Bourdieu 1977:78). The strategies that we select for our actions are also influenced by the capital we possess, which, as previously discussed, includes material economic, social, cultural and symbolic capital (Harker, Maher and Wilkes 1990:13). This chapter demonstrates that it is the interaction between factors from external social structures and the students' internal self-identity which creates their individual habitus. The biological components of habitus, including self-identity and personality add creativity to habitus (Hage 2013a). Thus each person's habitus is unique and this, in turn, decides the stance towards their impairment and the strategies that they select to use their capital to position themselves within society in general and with respect to their choice of future career. This analysis will underline the importance of considering each disabled student individually, even if they have the same impairment, as they will have developed a different habitus, possess different capital, and will employ different strategies in their positioning.

6.2 External Social Institutions

The two main social institutions that affected the students in their childhood were the family unit and the education system. Bourdieu (1993:33) stated that the family is the “main site of the accumulation and transmission of [social] capital”, whilst Bat-Chava (1994:495) emphasised the importance of the school and teachers at this formative stage of life. Bourdieu (1977:86) argued that the family structure underlies the structuring and internalisation of school experiences. Therefore these two structuring fields are interlinked as important fields for the development of habitus.

6.2.1 Family as a Social Structure

Clare grew up in a two parent family with sisters, whilst Alison's parents divorced when she was a teenager. She was living with her father and five siblings; although she does mention her mother's input in both her medical care and encouragement at school. The general doxa: core values or discourses (Webb, Schirato and Danaher 2002:28), about children of divorced parents is that it will affect the children in some way. Blow and Daniel (2002) highlighted the

large body of literature into the effects of divorce and separation, whilst acknowledging that a lot of this literature does not consider the social constructs around the institution of the family. However, they reported a reassuring outlook that most children from such a background develop a positive self-identity, suggesting that the most important issue is not the number of parents within the household but the quality of parenting by the adults present. Due to the increasing number of single parent households, statistically 25% of children are now raised by one parent (Gingerbread 2014), the current societal view of the family unit is changing. Although children may be raised predominantly by one parent, a lot of these children still have contact with their other parent, as in Alison's case, suggesting that Alison and her siblings may not have experienced the deprivation that some children do in a similar situation. This reveals the nuances within family structure: no two family units are the same and therefore any research surrounding this topic will always be ambiguous. Family structure also demonstrates the multi-dimensional characteristics of cultural capital. Our culture still values the two parent family unit as the optimum stability for rearing the next generation (Amato 2005:76). Therefore the two parent family unit bestows greater cultural capital on Clare than Alison. Yet professional qualifications are also held in high esteem within our society awarding both Clare and Alison cultural capital, as all of their parents have professional status. Consequently, Alison's lower cultural capital, due to divorced parents, is offset by her parents' professional status. However, Clare's family will still be seen as having higher cultural capital as her father is a doctor and this will also contribute to greater economic capital, with Clare's parents having greater disposable income than Alison's, allowing them the ability to employ private tuition to help Clare in her education (see 6.2.2).

When contrasting Clare and Alison's social interactions, we might expect to see a difference in their habitus due to their differing family backgrounds, demonstrating the interplay between external and internal factors in the development of habitus. It might be supposed that the child from a 'stable' two parent background would be more self-assured; the stability and cultural capital of the family unit would imply higher self-confidence. However, it is Alison who

seems to be more positive and proactive rather than Clare, who needs reassurance throughout her education to prevent her from accepting the social constraints placed upon her. In fact, the differences seen between Clare and Alison might encourage the suggestion that children of single parents have to use more strategies to improve their social positioning to compensate for the stigma of growing up in a 'broken home' and gain cultural capital. The possible reasons for the difference in their strategies again presents a complex picture of the myriad of factors between external and internal issues which interact to form habitus. In this instance Clare's family structure would give her an advantage; whilst Alison's later education support redresses this imbalance. Ultimately, the difference between the two students is their self-identity, as discussed later.

One factor which may influence the person's self-identity is having a role model who has an impairment. Clare reported that her Mum has a '*hearing disability*' whereas Alison did not mention any other disabilities within her family. It might be expected that a disabled parent would be more vigilant with supporting the medical interventions for their child, especially if they are also a health professional, yet Clare mentioned '*poor upkeep of going to appointments*', whilst Alison reported her Mum's constant attention during hospitalisation. The literature discusses parental responses to a diagnosis of hearing loss in terms of grief and loss (Kurtzer-White and Luterman 2003); stress (Hintermair 2006), and having to negotiate health and education systems (Glidden and Natcher 2009). Neither student discussed any negative responses from their parents about their hearing impairment (HI). As both of the students have parents who are HCPs (Clare: father is a doctor and mother is a midwife. Alison: mother is a nurse and father is an engineer) they would have been familiar with the healthcare practices and at an advantage in negotiating this system and all of their professional backgrounds would confer social capital when discussing their child's abilities within the health and education systems.

However, both sets of parents have dual, conflicting roles when considering their daughters' medical interventions: they are parents as well as

being HCPs. Esdaile (2009) argued that families and HCPs have different views on the impossible, possible, or probable outcomes of treatment for a child with a disability. Parents seek the impossible: the miracle cure; whilst practitioners are considering the possible: the current best practice, or probable: the most common outcome of the treatment. As HCPs the parents have a high level of tacit knowledge of the health care system. Bourdieu (1993:18) described this as a 'feel for the game': an awareness of the stakes coupled with the capacity to play and an interest in the outcome. They would be more aware of the stakes: the effectiveness of the proposed interventions; have a high capacity for the game: their tacit knowledge and ability to negotiate the system, and an interest in the outcome: a desire to improve their daughters' hearing ability. The role of parent and health professional will have impacted on their habitus, interacting and causing them a dilemma in selection of strategies to support their child. I propose that as both of Clare's parents are health professionals this might have been a greater dilemma for them resulting in a lower adherence to treatment.

Esdaile (2009) continued by suggesting that parents are in the dilemma of exploring treatments to reduce their child's impairment, whilst valuing and loving the child in their existing state. In Clare's situation this paradox may have been heightened for her mother. Firstly, she may have had similar treatment to those being proposed for Clare in the past and gained no benefit. Higson and Haggard (2005:624) asserted that past treatments for OM were unselective and based on diagnosis rather than potential advantage. Thus many children had grommets fitted although they would gain little benefit. If Clare's mother was one of these children she would be reluctant to subject her daughter to surgery which had not helped her. This dilemma might also have been confounded by Clare's father's role as a general practitioner (GP). OM is a very common childhood condition with most cases resolving without treatment. Any associated HI is usually countered by the insertion of grommets or 'T-tubules'. Only a small percentage of children go on to have a permanent hearing loss as a result of the condition (Higson and Haggard 2005:624). Therefore, Clare's father's past experience of children with OM would be of a self-limiting condition that does not cause any permanent damage. Consequently, he also may have erred towards the probable

rather than the possible outcome and under-estimated Clare's need for intervention.

Secondly, Clare's mother has learned to cope with her HI within society and to achieve a high status as a HCP. This strategy was one that she has developed based on her past experience of reactions to her own HI. Bourdieu and Wacquant (1992: 82) asserted that dominated people, such as disabled people, have to choose between two options which Bourdieu considered are equally bad. They can offer resistance to their domination, but this often causes an increase in their domination: or conform to the system, which requires submission and serves to reproduce the existing social structure. It would seem that Clare's mother chose the latter solution by assimilating within the existing structures, a choice that is made by the majority of disabled people in the form of normalisation (Darling 2003: 884). The above factors would have become integrated into her habitus and have influenced the way in which she interacted with Clare and also the perceived importance she attached to the medical interventions. Thus she may not have perceived Clare's HI to be a problem, encouraging her to utilise the communication abilities that she possessed to assimilate into 'normal' society.

It is widely acknowledged that the effects of disability are not only felt by the affected child and parents, but also any siblings in the family unit (Moore, Howard and McLaughlin 2002). Alison mentions the impact of her repeated hospitalisation on her family and expands on this topic:

"... having operations and long hospital stays because of my ears ... made me have a closer bond to my mum. My sisters say that I was always her favourite and maybe I was, but I never felt that way when I was younger, as we were all treated in the same way". [Alison]

Clare, on the other hand, does not mention her relationship with her older sisters; except in the context of academic achievement at the point of transfer to senior school (see 6.2.2).

The reactions of children to given situations are based on the actions and strategies they observe displayed by significant adults, as children imitate these adults (Bourdieu 1977:86). Therefore, children respond to situations in a similar way to their parents. From a Bourdieusian perspective our parents' actions, behaviours and sanctions are integrated into our habitus, setting the social norms and rules for the family unit: the children will replicate their parents' behaviour. Clare's parents' reaction to Clare's impairment appears to have been a normative approach: treat her as if there is no impairment and encourage her to assimilate into normal society. Modelling of this behaviour by Clare's siblings would be one explanation for Clare not mentioning any reaction from her sisters.

The behaviour we experience and emulate from the social structures interacts with our innate instincts to create habitus. Atkinson (2011:341) argued that although the family operates as a field the individual children compete with each, otherwise known as sibling rivalry. Consequently, a child's habitus will develop from the interaction of complying to the social norms whilst struggling with the natural innate jealousy of siblings. Alison's previous quote captures these conflicting emotions: acknowledging the jealousy of her siblings whilst refuting any difference in parenting behaviour. Moore, Howard and McLaughlin (2002) performed a literature review of studies about the reactions of siblings of children with disabilities. They found that, contrary to previous beliefs, the reactions of siblings were not as negative as previously described in the past. The authors emphasised that the relationship between siblings develops within the dynamics of the family. Along with parental attitude, as already discussed, other factors contribute to the adjustment of the siblings including, age, position in the family hierarchy, and attending the same school. A later study investigated the responses of children with a sibling who has a speech impairment. They reported that whilst these children did identify with feelings of jealousy they also reported positive relationships with their sibling, confirming the interaction between natural instincts and social norms (Barr, McLeod and Daniel 2008). In order to protect against sibling rivalry a child will use strategies to improve their position within the field; in this instance the family unit. Alison confided that *"I did give them [her siblings] benefits such as lip reading the adults and telling them*

what they couldn't hear, which they found was cool". This is an example of Alison's learned experience incorporated into her habitus causing an unconscious strategy to improve position within the family field, gaining social capital, to negotiate her position within the family group (Bourdieu 1990a:75).

6.2.2 Educational Background

Bat-Chava (1994) maintained that, alongside the family, schools are also important for socialisation of children. From this perspective it would be expected that Clare and Alison would develop a similar habitus; as both attended mainstream school. The students did share similar experiences with their educational attainment and socialisation, but these were dealt with differently in each situation creating a different habitus in each student.

In the first instance, both Clare and Alison discussed how they felt socially isolated during their school life.

"...if you are in a big group it did kind of cut you out socially 'cos they'd all be talking and you just could not follow the conversation so I think that kind of isolated me." [Clare]

"...but I kept myself to myself and was very much an individual." [Alison]

However, only Alison mentions any discrimination with respect to her HI:

"I was bullied throughout all of my schools but I was lucky to have the support [from the teacher of the deaf]." [Alison]

This social isolation may have been due to the repeated hospital appointments and medical treatment for their OM. The consequential reduced attendance at school would have limited the time the two girls got to interact with the other children, both within the classroom and socially. This would have been compounded by the communication difficulties that their HI would have created. A link has been established between communication difficulties and social isolation for children with HI (Crowe 2003; Eriks-Brophy *et al.* 2012). This social isolation, and in Alison's case bullying, creates a barrier between the children and their peers, which is reinforced by the general opinion (doxa) that people with disabilities are different and 'always off sick'. This generalised negative opinion

that impairment equates with sickness, can affect disabled people for the whole of their lives and particularly their work potential (Lopez Gonzalez 2009). The negative attitudes expressed towards disabled people create social oppression; such as the social exclusion reported by both students and the bullying experienced by Alison, and social impositions, which constrain the activities of people with impairments (Thomas 1999). These constraints may create negative emotional responses, which become internalised and oppressive. In Alison's case, because she was good at sport, she had the ability to gain positive attitudes from her social interaction at school; counterbalancing the bullying; avoiding internalised oppression, and gaining social capital. Clare also gained positive feelings from physical activity, through dance, an activity external to her school. She demonstrates the importance this had on her social acceptance by stating: *"I felt like I belonged"*. However, to some extent, it increased her social isolation at school as it happened *"outside of school"* and thus did not inhibit the internalising of oppression or improve her social capital at school.

Both Alison and Clare identified entering the school's sixth form as being the time when they finally felt less isolated. Clare commented that *"class sizes got smaller so that made it a lot easier and I think [this] is where I really thrived...as the years went on...I think everyone just...accepted me"* whilst Alison mentioned that *"it wasn't until sixth form that I began to socialise with my friends outside of sport and school, as I felt comfortable in their company and didn't feel judged by them"*. These comments highlight two factors that contributed to the girls' increased social capital: a change in social structure (reduced class sizes) and an increased acceptance from their peers. Within further education the curriculum encourages small group interactions incorporating student discussions and project work (Office for Standards in Education, Children's Services and Skills 2014). For people with a HI smaller class size augments their hearing and facilitates their communication skills. This type of teaching also encourages more social interaction between students, which helps to break down social barriers that may have existed during the earlier school years, so that students become more familiar with each other, accepting their differences in a non-judgemental manner. From a Bourdieusian perspective, the changes in the social structure

[smaller class sizes and increased interaction within class] generated an evolution in the habitus of all the agents [increased familiarity adapted the students' habitus] and an increase in Alison and Clare's social capital [the increased social interaction allowed both students to create relationships with their peers which extended beyond the school day] (Harker, Maher and Wilkes 1990:12). This demonstrates the creative nature of habitus (Hage 2013a); it is not fixed but open to change (Bourdieu and Wacquant 1992:133). Using Social Identity Theory (Brown 2006) the move into sixth form and more adult styles of teaching generates a new formulating of the group concept and identity: this increased familiarity with Alison and Clare reduces the cognitive bias against them being identified as 'other'. The students realised that they have a lot more commonality than difference and therefore Alison and Clare became identified within the group, rather than group outsiders. Thus their differences are overlooked by their group as idiosyncrasies rather than reasons to identify them as 'other'.

Social Identity Theory is considered by Bat-Chava (1994) who argued that deaf people are a specific minority group and therefore subject to stereotyping and stigmatization. He asserted that children of minority groups are usually raised within that specific minority community (e.g. British Asian children are raised predominantly within a British Asian community) thus receiving insulation from these factors and gaining positive identification within the group. However, deaf children of hearing parents, such as Clare and Alison, are often brought up within the mainstream school system, isolated from support from other deaf people, leaving them exposed to prejudice and discrimination, as experienced by Alison (Eriks-Brophy *et al.* 2012). When considering people with a HI there is a categorisation between people with an impairment and those who self-identify with the linguistic and cultural effects of a HI. This categorisation is underpinned by the different written usage of the word deaf. When it is used in lower case it represents people with a HI who strive to be part of the hearing community (individual model of disability and normalisation orientation). However when it is capitalised 'Deaf' it refers to a person with a HI who also recognises and identifies with the Deaf culture (social model of disability and affirmative

response) (Barnes, Mercer and Shakespeare 1999: 204). Alison and Clare have both been educated within the mainstream school system and in isolation from the Deaf culture; however Alison's school support has acknowledged the linguistic effects of her HI giving her some linking to the Deaf culture, which may have contributed to her affirmative stance. Interestingly, although Clare's mother also has a HI, Clare has had no contact at all with the concept of deafness other than as a medical impairment.

In addition to their issues with social isolation Clare and Alison both discussed problems with their educational achievement in primary school and their parents' encouragement in overcoming these difficulties. Eriks-Brophy *et al.* (2012) identified that the language difficulties that children with a HI may have can affect their academic progress. Alison's learning difficulties were addressed by support from a 'Teacher of the Deaf' (ToD) whose role was to support Alison on a one-to-one basis in English during the school curriculum. Alongside this learning role the ToD has a role to support both the child and family with interpretation of medical reports and the provision of impartial advice (British Association of Teachers of the Deaf 2009). This allowed Alison *"to learn at the pace with the rest of the class"* either within the class situation or sometimes on a one to one basis, which created a positive attitude to learning in Alison, which she identified, discussing herself as being more motivated and determined than her siblings. Alison's integrated support was part of the daily school structure; accepted by her, her teachers, and her peers. It allowed her to maintain a similar rate of learning as that of her cohort, increasing her social capital. The provision from a specialist ToD recognised the cultural and linguistic barriers to education as an additional layer of disability experienced by people with HI (Bhaskar and Danermark 2006). This support, and Alison's determination, created an assured outlook in her own abilities to the extent that she was confident enough to discount the advice from teachers and career advisors regarding her application to physiotherapy (see 6.4), and to reduce the level of support she received over her 'A' levels in preparation for the expected need to be more independent at university. This indicates a strong internal locus of control: recognising her own role in her learning and development (see 6.3.1).

Unfortunately, in her early school life, at approximately the age of seven, Clare “took key stage one SATS [Standard Assessment Tests] tests and failed those miserably” as she had been receiving no support from the teachers: “she never complained so we didn’t think it was a problem”. In response to this Clare’s parents arranged for her to have extra tuition after school so that she could achieve the expected academic level for her age. This “constant catch-up” continued for Clare throughout her schooling and contributed to a negative view of herself as compared to her peers: “like I was... the less academic one in my group”. However, Clare’s support was provided outside of the regular school day and seen as extra, by both her and her teachers; to encourage her to “catch up”, reinforcing her feelings of inadequacy, low self-esteem, lower social capital and an external locus of control. Her support solely focused on remediation of Clare’s academic impairment: in her individual need to ‘catch up’ and therefore was situated in the individual model of disability, not accounting for any linguistic or cultural difficulties. Clare’s feelings of inadequacy were compounded when she reached the age of eleven and the transition period to senior school. A teacher advised her parents to send Clare to a comprehensive school rather than sit the eleven plus assessment for the grammar school, which her sisters both attended: “‘well she’s borderline... so don’t think she’s going to follow in their [her sisters] footsteps’”. This negative comparison with her sisters originated from a highly influential source for the development of habitus in a child: her teacher. Bourdieu and Passeron (1990: 6-7) discussed the symbolic violence within pedagogic action. The dominant group in the field of education [the teacher is an expert in education and therefore knows best] identify what is of specific, symbolic, importance [taking the 11 plus exam] and use violence to emphasise the inferiority of those who cannot attain this goal [“she’s borderline”]. Bourdieu warned that agents are complicit in their own situation because they internalise the symbolic violence misrecognising it as the natural order and incorporating it into their habitus [her impairment causes her to be less academic] (Webb, Schitaro and Danaher 2002:25). These comments by the teachers are evidence of the underestimation of the abilities of children with impairments (Baron, Phillips and Stalker 1996) and are repeated by teachers and careers advisors when both

Clare and Alison identify physiotherapy as their profession of choice (see 6.4). Clare internalised this oppression, seeing herself as inferior to her peers *“I always felt... the less academic one”*.

These social barriers, created by social institutions such as the education system, interact with emotional issues and compound each other (Thomas 1999). Ladd (2002) discussed a similar educational background to Clare, being brought up isolated from other deaf people in mainstream schooling. Although he achieved academic success to HE level, he felt this approach caused social and emotional problems. He recounted his personal realisation of his oppression and integration into the Deaf community. The National Deaf Children’s Society (NDCS) were concerned that a lot of children were growing up in this situation and developed the ‘Deaf Role Model Project’ (2006-2009) to address it, improving the children’s self-esteem in order to “build deaf students’ social capital” (Rogers and Young 2011). It would seem that Clare’s social trajectory mirrored that discussed by Ladd (2002) being brought up to assimilate into the hearing community with no experience of Deaf culture. Her extra provision and social isolation not only led to feelings of inadequacy, but also an internalisation of difference and oppression, resulting in her avoidance of causing a commotion: *“I don’t like fuss”*. In contrast, Alison’s support from the ToD introduced some linking to the Deaf community, helping her to develop her identity as belonging to the group. I would argue that the difference in approaches to supporting the students was a crucial factor in the differences in their stance towards their disability. It created a positive, affirmative approach in Alison and a hesitant, self-deprecating response in Clare.

In summary, habitus is constructed from all learned experiences and early life experiences are very influential on the development of self-esteem and identity. Giddens (1991:3) suggested that this identity develops from a basic trust in the early caregivers as a defence from the anxiety, risks and dangers of the unknown: “they will protect me!” A child endows this trust in parents, and teachers once they start school. For Alison this trust was reinforced by individual

attention from the ToD supplementing the care given by her parents and her class teacher, building self-confidence and self-assurance. Unfortunately, for Clare, at the age of seven, her trust in the protection by her teachers was shaken when she failed her SATS '*miserably*' and the chaos of existence was revealed. Her parents and teacher did not protect her and the consequence of the failure was the need for Clare to '*catch up*' with the other children. Crowe (2003) asserted that a distorted self-concept can develop in deaf people if they perceive themselves to be inadequate in comparison to the general population, creating internalised oppression. Clare voiced this inadequacy by commenting on her frustration and feeling less academic.

Whilst both Clare and Alison have the same medical diagnosis and were both brought up in the hearing community within the mainstream school system, their socialisation during these formative years has been subtly different. The family-school relationship Clare experienced was a normalising one. Both her parents and the school system focussed on treating her as a normal child with extra provision to improve her academic achievements. This normalising approach can be seen as a valid pragmatic strategy; teaching the child to survive in the potentially harsh world. Her early development focused on academic achievement to increase her social and cultural capital to a level that would minimise any reduction due to her HI. However, from a Bourdieusian perspective, this can be seen as the replication of the social structure using relationships to reinforce the doxa of normality. The educational input Clare has experienced has had a constraining effect on her habitus causing her to misinterpret her academic ability as being her fault and lower than her peers and sisters, rather than the school system not providing reasonable adjustments to support her impairments in her early education. Northway (1997:738) referred to this doxa as "Cultural Imperialism" resulting in internalisation, discrimination and the marginalisation of disabled people. The personal effects of this are a lack of self-confidence, poor self-esteem, denial, worthlessness and disempowerment (Reeve 2006).

In contrast Alison's family-school relationship acknowledged her hearing impairment. She was provided with educational support within the school

curriculum specific to her impairment. Thus the social structure implemented adjustments to minimise the barriers Alison experienced. This approach helped Alison to develop an affirmative reaction to her impairment. She acknowledged her impairment, but did not see it as having negative implications on her identity or social trajectory.

6.3 Identity: Internalisation of Social Influences

Shakespeare (1996:94) asserted that a person's identity is composed of both an active component (the identity given to you) and a reflexive component (self-identity). Unfortunately, the identity given to us by society can become internalised into our own habitus affecting our self-identity by the processes of *illusio* (commitment or investment in 'the game' (Bourdieu 1993:116)) and *misrecognition* (agents misrecognise socially created rules as 'the natural order' (Webb, Schirato, Danaher 2002:25)), which serve to prevent transformation and evolution of habitus. Yet the situation is not entirely bleak; Bourdieu claimed that habitus is open (Bourdieu and Wacquant 1992:133) and Hage (2013a) spoke of habitus being creative. Thus the internal reflective elements of habitus, such as self-identity and personality, combine with the external components creating a person's habitus. The previous sections have served to reveal the active component of identity exposing the influence of external social structures and the internalisation of these factors into the development of habitus. I contend that Clare demonstrates this as internalised oppression and I will establish this by contrasting her use of language when discussing her impairment with the manner in which Alison relates to her disability. I discuss how the students' internal response to their impairment creates a different locus of control and stance in each student which goes on to affect their strategy, as demonstrated in their choice of physiotherapy as a career. Finally, I consider how the students' habitus, particularly Clare's, began to evolve across the course of this research project as they reflected on their past and the concept of disability within society.

6.3.1 Self-Identity: Reflective Component

*"...left permanent perforations in both tympanic membranes, which automatically decreased **the** hearing". "...being let down **by** hearing" "I*

hate making an issue out of it.” “I’ve got a hearing impairment so I won’t be as good as anybody else” [Clare] [my emphasis]

I maintain that the above quotes taken from Clare’s interviews demonstrate her internalisation of the normative approach that she has experienced to this point. She has been encouraged to minimise her impairment and she performs this by using passive pronouns, ‘the hearing’ and ‘it’ [my hearing] when speaking of her hearing, revealing a subconscious denial of disability. She shows embarrassment about her impairment: “*I hate fuss*”, whilst the final statement exhibits worthlessness and disempowerment.

Bourdieu and Wacquant (1992: 142-150) emphasised the importance of exploring language as a social demonstration of symbolic power. It is vital to study not just the words used, but the relation of these to the situation, both temporal and spatial, in which they are spoken. Bourdieu insists that power relations are an important, yet often invisible, context to verbal communication. In relation to this, Bury and Monaghan (2013a:81) discussed that narrative and language are a form of communicating socially constructed shared identity. Thus the negative concept of disability is shared using negative language associated with a biological impairment: dis-abled [asunder or apart from ableness]; in-valid [worthless]; impaired [damaged]: it is very difficult to think of a positive word or phrase which is used affirmatively to describe impairment. This indicates the symbolic power of language used by the dominant group [non-disabled] to identify and separate from the dominated group [disabled people]. Thomas (1999:116) and Reeve (2006:101) contended that this use of language is a form of social oppression causing internalisation of society’s negative doxa towards disability. Similarly, Clare’s use of language shows her internalisation of this negative doxa and her attempts to dissociate from disability and her impairment; which are negative and associated with low social capital. She appears to use language as a strategy to increase her own identity and power by positioning herself as separate to her impairment. It might also be considered that her use of impersonal pronouns indicates her external locus of control: her hearing being external to her identity and thus she has no control over the consequences of her impairment.

As a child she demonstrated this external locus of control as an acceptance of her situation as being the natural order *“I didn’t think I’d have to listen”* (not complaining about not being able to hear and the lack of support from teachers). In fact she continued to display this passive acceptance during her choice of career and whilst on her physiotherapy course (see 6.4). This internalisation of oppression displays the emotional response to disability discussed by Bhaskar and Danermark (2006), Hosking (2008) and Thomas (1999). Bourdieu’s theory of practice indicates that this internalisation occurs because the agent is immersed in the social field and subconsciously aware of the importance of social capital for their positioning. The agent also misrecognises the discourses about their capital and accepts them as truths rather than socially constructed ideas. In Clare’s case her investment in the ‘game’ is situated in a normalisation orientation (Darling 2003) and she accepts the natural order that her hearing difficulties mean that she is below the academic standard of her peers and siblings and therefore of less worth.

In contrast, the following quotes from Alison appear to indicate her affirmative stance towards her impairment.

*“I was always ill...because of **my ears**”. “I was pretty normal I just don’t hear as well...” I have a disability, I’m hearing impaired... that’s what society has told me,...but ... **I don’t view the term disability negatively**” [Alison] [my emphasis]*

The use of personal pronouns, when describing her hearing, demonstrates that she accepts her hearing impairment as part of her persona, giving her a positive, self-confidence that Clare lacks. Her identification with the label of disability shows her understanding that disability is a socially ascribed concept, whilst her rejection of the negative doxa given to this label shows her affirmative outlook. This is demonstrated by her positive use of her lip reading abilities to ‘spy on the grown ups’ as a child. She rejects the individual model of disability: the tragic individual in search of a cure, and embraces the affirmative model: viewing her

life in positive terms to be celebrated (French and Swain 2012:23). To this extent Alison has challenged the natural order and 'recognised' that there are other options for actions. Her investment in the 'game' is based on acknowledging her disability and then being proactive to establish her social capital.

Acknowledgement of the social concept of disability seems to have great significance with respect to the development of habitus and identity for the students. Students were asked if they identified with the label 'disabled' as this self-declaration is needed when completing the Universities and Colleges Admission Service (UCAS) form because their access to support at university is dependent on them ticking a box indicating that they have a disability. Clare, along with the majority of students, did not identify with the label of disability:

"I always think of a disability as something that stops you from being able to do or take part in certain things..." [Clare]

However, Alison had a different view:

I have a disability,... that's ... the label I've been given... However on a daily occurrence I don't feel I have a disability I'm fortunate that I'm fairly independent although there are always occasions when my disability burdens me." [Alison]

These quotes suggest that the majority of students, along with Clare, have internalised the oppression of disabled people by seeing the label as being negative and trying to extract themselves from being grouped as 'the disabled'. In Clare's instance she demonstrates her internalised oppression by trying to avoid discussions about her hearing, viewing it in a negative way;

"I always didn't like talking about hearing because it was making it into a problem. It was like 'you've got an issue..." [Clare]

adopting a general 'low profile' approach;

"I just, that's the one thing I hate about it: I hate creating fuss". [Clare]

and being very self-conscious about her hearing aids;

“...put hearing aids on me and I’ll be rejected by everyone!” [Clare:
Comment about being prescribed bilateral hearing aids in year 9 of school]

“because I always think my hearing aids are really obvious...they’re huge!”
[Clare: discussing responses to her impairment whilst on clinical
placements]

She tries to distance herself from her impairment by emphasising alternative ways of communication other than hearing:

but the beauty of hearing is that there are always ways to go around it”
[Clare]

Bat-Chava (1994) emphasised that an important factor affecting self-esteem for deaf people is not group membership, but identification with that group. Therefore, Alison’s positive view of disability and identification with the group reinforces her self-esteem. However, Clare, and the other students (see 7.4) did not identify with the disabled group, although they may be viewed as members of the group by others, resulting in their lower self-esteem as indicated by the words they use to describe their feelings about their impairments. Martz, Livneh and Turpin (2000) suggested that a disabled person’s locus of control is linked to their cognitive and emotional acceptance of disability; acceptance being associated with an internal locus of control. Clare has not accepted or adjusted to her disability and exhibits an external locus of control: expecting that she has no control over events or actions that affect her. This is revealed in her passive acceptance of not being able to hear at primary school; being advised against sitting the grammar school examination, and being advised against applying to study physiotherapy. Her normalisation orientation causes her to suppress her need for support by *‘not making a fuss’* and to attempt to minimise her impairment, implied in her self-consciousness about her hearing aids. Conversely, Alison overtly discussed her acceptance of her disability and shows a high level of adjustment to her hearing impairment: she also wears bilateral hearing aids, but is not embarrassed by them. Therefore she exhibits an internal locus of control, proactive coping strategies and an affirmative orientation (Darling 2003).

6.4 Strategies to Increase Capital: Choice of Physiotherapy as a Career

Bourdieu (1990a:63) emphasised that agents will choose strategies to improve their position within a social field. This is achieved by the expression of existing capital or the acquisition of further capital. If people are given a low position by the dominant group they will use, or attempt to acquire, capital to increase their power and status. Therefore, in order to avoid the negative labelling associated with being a member of a group labelled as 'disabled', individuals will emphasise other capital, or attributes, which separated them from this group. They will also strive to gain membership in a higher status group. An example of this positioning occurred in my study when Hannah emphasised the multi-faceted nature of her self-identity:

“first and foremost I’m a student and an athlete, 95% of me is that and 5% is disability” [Hannah]

She identified most with labels that confer greater social capital: athlete (identifying with the image of strength and fitness) and student (identifying with the prospect of increased cultural capital through the gaining of a higher academic qualification). Only a very small component of her identity was linked to the lower status of disability. When I explored this multi-faceted identity with Clare and Alison in their second interviews they both agreed that they identified most strongly with the label physiotherapist, positioning themselves into a professional group with a higher social and cultural capital. This is not surprising as the label of disability identifies membership in one of the lowest social groups. Watson (2013) claimed that disabled people are the largest minority group in the world, whilst Oliver (2009) stated that 60% of disabled people within Britain live below the relative poverty level and are three times more likely to be unemployed with only 0.3% continuing their education to HE level: in 2013 this equated to 2.7 million disabled people living in poverty (Duffy 2014). In a report for The Centre for Welfare Reform, Duffy (2014) highlighted the cumulative impact of all the austerity measures (housing, care and income benefit cuts) on disabled people. Williams (2014) linked this centrally imposed social policy, along with television programmes such as Benefit Street, to the increase in hate crime against

disabled people. Against this societal picture of disabled people living in poverty, being 'benefit frauds,' and a 'drain on society,' it is hardly surprising that the students in this project sought to distance themselves from this group and to improve their social capital by identifying with a professional group, such as physiotherapy.

Therefore, the choice of physiotherapy as a career may be recognised as a strategy to improve the students' social, economic and cultural capital. In choosing this career path both students sought advice, Clare from her Father, whilst Alison used the connexions service (careers advice services at local government level which have now been disbanded) at her school. Clare wanted a career that incorporated her love of dance and movement with her interest in medicine:

"what can I do with the anatomy and movement; physiology and stuff and he [said] "a physiotherapist" ... and [that's] when I realised that's what I wanted to do". [Clare: year 9, aged 11-12]

Initially Alison wanted to be in the police or armed forces, or become a doctor:

"It wasn't until I filled out a questionnaire which states the jobs most suitable to your personality and ability and thought physiotherapy sounded unusual. [I] looked more into it and realised it was something I was interested in, helping people to gain their independence." [Alison]

However, both experienced discouragement from pursuing this idea from school teachers. Interestingly, both were advised to opt for being a PE teacher instead.

*"... 'cos teachers, **constantly constantly, constantly** said "no she can't do physiotherapy,... she'll let herself down if she does it" There was not one teacher who said "yeah, go for it. So when teachers said that, ..., they said ... become a PE teacher ...[Clare; her emphasis]."*

"They portrayed physio to be hard and in all honesty to some respect discouraged me from continuing with that career prospect ... Basically they didn't think I would get the grades, which just made me more determined

to work harder ... My P.E teachers were great at giving me advice although they did try to persuade me to become a P.E teacher instead.”

[Alison]

These discouraging comments from teachers may not necessarily be based on any overt discriminatory opinions, but on the perception of physiotherapy as a career choice and the negative assumptions associated with disability, which Deal (2007) recognised as aversive disablism. The difficulty in gaining a place to study a physiotherapy course is widely acknowledged (Total Jobs 2014), with the entry criteria being set higher than average due to the level of competition (NHS careers N.D.). The intensity of a physiotherapy degree and hard work required in the job is also highlighted to prospective applicants (Total Jobs 2014). Therefore, these teachers may have been trying to shield pupils they had observed struggling at times within the school situation from failure, indicating an under expectation of the abilities of a child with an impairment (Baron, Phillips and Stalker 1996). In addition to this, the general doxa is that physiotherapists are fit and healthy and physiotherapy is therefore not a profession suited to people with a disability. There is a paucity of information available to correct this erroneous perspective and to indicate that physiotherapy is a profession which is able to accommodate disabled students (see 7.9.1).

Both Clare and Alison responded to this discouragement with a sense of determination to prove the teachers wrong. In fact, all of the students in the study spoke of being determined or highly motivated. However, due to her lack of self-esteem Clare was initially willing to accept this constraint:

I automatically, would just sit there and [think], ‘O.K ...I’m not good enough ... I’ll just teach dancing for the rest of my life’. And My Dad [said], “no, you’ve got brains, you can do it, ... so don’t listen to what the teachers are telling you.” [Clare]

It was her father that rejected the advice encouraging Clare that she was good enough and to strive for her original goal. Brown, James and MacKenzie (2006) suggested that students with disabilities feel that society underestimates their

abilities. Therefore, the students need to prove themselves worthy, and to some extent better than their non-disabled colleagues. From a Bourdieusian perspective this determination can be seen as economic capital that disabled students have to possess in order to overcome the doxa that people with disabilities are not capable of succeeding and should therefore not consider a highly competitive degree such as physiotherapy. Students who do not possess this economic capital or who do not have parents who encourage them to be successful may not get beyond the initial inquiry into physiotherapy as a potential career. At the outset of this project I was aware that recruiting existing physiotherapy students was a potential flaw as I was not accessing those disabled students who were deterred from continuing with their dream.

In a later interview Clare commented:

“having been told at school that I wasn’t clever enough to be a physio, ...I feel like going back and [saying] look at my degree that ... you told me I’d never get”.[Clare]

The students agreed that this determination was required to deal with the extra issues related to their conditions that need sorting out, e.g. applying for the Disabled Students’ Allowance (DSA)[Helen], or to cope with problems along the way [Sally]. Fuller et al (2004) discussed the extra preparation that disabled students have to undertake to set up their support package during the transition to HE. Therefore, this determination is an economic capital which is essential for disabled students to possess in order to succeed.

6.5 Increased Self-Awareness: the Evolution of Habitus.

Being part of this project and discussing issues with the interviewer and other participants may have been beneficial in encouraging the students to reflect on their situation and strategies, and develop more capital. The iterative design, the narrative and reflective nature of the data collection methods used, and the process of engaging with their own and other participants’ data have caused the students to be reflexive about their own self-identities. Clare definitely demonstrated an evolution of her habitus, identifying that she needed to become more assertive:

"I think it would be better for me to be more assertive; that would be my challenge". [Clare]

and choosing to do her final year dissertation on the experiences of disabled students during clinical placements. This development shows how our habitus can be transformed by recognition that there are different ways to act [challenging the natural order or doxa] and rejecting the cultural assumption that an impairment makes you inferior [Illusio] and become more confident and self-assured. In Ladd's (2002) case this guided him to involvement in the Deaf community and political activism. Oliver (2009) referred to this as politicisation, where people become aware of the misrecognition that has oppressed them and begin to seek to change their circumstances. This increased self-awareness and transformation of one's own habitus of itself will not create social change: this requires awakened people to group together to strive for liberation. In Clare's case I feel that her involvement in this project has started this process of self-reflection and increased her consciousness to the point of using her own undergraduate dissertation to strive for social change within clinical placements for disabled physiotherapy students. However, once she enters clinical practice as a qualified professional the process of institutional socialisation will begin. This will again be focused on normalisation and assimilation, and the influences will be strongly encouraging Clare to conform and replicate the existing structure: a response she has acquiesced to for most of her life.

To summarise, habitus is a combination of external and internal factors which contribute to the selection of strategies used to position oneself in the field of power. In Clare's instance, the external factors have encouraged her to conform to society, internalising the negative doxa against disability. This in turn has produced a lack of self-confidence and assertiveness in her internally generated aspects of her habitus. Conversely, Alison's external factors acknowledged her impairment leading to her feeling comfortable to identify with her hearing impairment and the label of disability. This created a self-confident, affirmative nature to her internally generated aspect of her habitus. Whilst they possess a different habitus at the beginning of the study, there is evidence that,

through reflexivity, Clare has started to become more aware of her internalisation and demonstrated an increase in her self-confidence when discussing her disability: here habitus had evolved.

Alison is the only student within the study who identified with the label of disability in an affirmative manner. All the other students, including Clare, saw the label as very negative and did not associate with it. Although Alison had an affirmative view she identified most with the label of physiotherapist (as did all the students). This demonstrated one strategy used by the students to increase their social capital, by gaining a professional status, and their cultural capital, by gaining a higher qualification.

6.6 Summary

This chapter has explored the interactions of social practices that contribute to the development of habitus, capital and strategies that students possess, using Clare and Alison as examples to contrast how almost imperceptible differences in social experiences can result in nuanced habitus, creating opposing stances and strategies. As childhood is such an important time for this development, it was necessary to return to the students' family and school backgrounds to investigate these differences and how the external and internal factors have interacted to affect each student's habitus. The overwhelming influence of social structures on the development of habitus has been discussed showing that the learned experiences within the family and school had a profound effect on the development of the students' habitus. However, Bourdieu (1990a:116) did not accept structuralism. He argued that agents possess control to defend or transform structures. This is expressed, often sub-consciously, in the way that they become involved in 'the game' and the strategies that they utilise to exert or gain capital in a struggle to achieve and maintain power.

The use of Bourdieu's theory of practice has allowed a detailed investigation of the students', their families and their school's response to a HI. In

the case of Alison the combination of factors has created an individual who received support from parents and school to acknowledge and adjust to her impairment resulting in her developing an internal locus of control and an affirmative approach to disability. Whereas Clare's family and school did not encourage her to acknowledge or adjust to her impairment, but to assimilate into the hearing community, with support solely focused on academic adjustments. This created a person who has a normative approach and an external locus of control. Both have gained cultural capital from their family background and chose to increase this by studying for a degree and professional qualification at university. All of the students recognise their determination as a necessary social capital to ensure success and they are unsure that disabled students not possessing this determination will succeed.

This analysis has emphasised the inadequacy of both the individual model of disability and the social model of disability, which only consider the individual or society respectively as being responsible for the experience of disability. It has highlighted the nuanced practices that interact within disability creating the laminate system portrayed by Bhaskar and Danermark (2006) and Gable (2014). These multifaceted explanations of disability indicate why each person with a disability needs to be considered individually as they will each have different social and educational backgrounds intertwining with individual internal components to create a unique habitus coupled with differing strategies and capital, which they will bring to the field of physiotherapy.

In order to enter the physiotherapy profession it is necessary for the students to use their strategies and capital to position themselves within the physiotherapy field of power. This current chapter introduced positioning when considering the choice of physiotherapy as a profession. The subsequent chapter considers positioning within the field at a more detailed level, discussing the strategies and use of capital as a power struggle to gain and maintain position within the field. It also discusses the response of the dominant group within the

field (the physiotherapy 'establishment') to the inclusion of disabled students into the profession.

Chapter Seven: Practices within the Field: The Experiences of Disabled Physiotherapy Students

“Disability is always an interaction between features of the person and features of the overall context in which the person lives” (World Health Organisation 2002).

7.1 Introduction

The previous chapter considered how both internal and external factors shape the development of habitus, which gives the dispositions that people use to position themselves in a field (Bourdieu 1977:3). This positioning results from the use of capital and strategies by the agents. Hence, this chapter discusses the practices that the disabled student participants used to position themselves within the field of physiotherapy education in relation to each other and the established members of the field. These were identified in stage four of the critical narrative analysis using the overarching themes of negotiating identity, development of capital and negotiating learning support developed from the participants' collaborative analysis of the interview transcripts (appendix Q). I also appraise the physiotherapy education system to explore facilitating and constraining factors the students have encountered during their socialisation into physiotherapy.

Firstly, I discuss how the students constructed their identity within the field and how this affects their integration into the profession. One of the key issues concerning negotiation of identity is the need to disclose their impairments in order to access support. The choice to disclose is affected by their self-identity and the perception of how other people view them. In order to investigate this I compare the students' comments against the general doxa of disability and also the corporeal standard. I propose that this struggle to negotiate an identity is against the specific concept of ableism; depicted more narrowly within the physiotherapy doxa, which I refer to as the physiotherapy corporeal standard. All of the participants have had to prove their worth and work against the misrecognition and *illusio* within the physiotherapy profession, but I suggest that students with a visible or physical impairment meet with more symbolic violence

than those with hidden impairments, due to the ableist attitudes within physiotherapy.

Secondly, establishing a professional identity requires the students to position themselves to increase their powerbase; this is accomplished by the strategic deployment of the various forms of capital which they possess or seek to increase. As previously discussed, Bourdieu (1993:34) used the analogy of gambling to describe the distribution of capital possessed by a person (see 4.5.4). A person's total capital may be constituted from the different amounts of the different forms of capital they possess. Within the physiotherapy field the disabled students possessed different capital in different amounts and the importance of the different capital in accruing position and power is discussed. I argue that physicality is a symbolic capital within physiotherapy, again due to the ableism within the profession. In the post-Francis era, a highly prized symbolic capital sort in HCPs is empathy to increase the care and compassion shown to patients. Historically it has been claimed that disabled HCPs demonstrate greater empathy and the students in this study supported this premise. This is explored by referring to the systematic meta-synthesis of empathy conducted in stage one of this study.

Finally, disabled students also have to negotiate their learning support. This process begins at entrance to the profession; during the admission cycle into their chosen university and course. I discuss the availability of information on the internet and whether this projects an accepting environment to disabled students. I consider how students negotiate their individual learning needs within the normative university system, analysing the participants' experiences of this support, both within the university and clinical placements. I conclude by assessing the equity within the system to establish if a level playing field achieved or, as one student suggested, whether it is still more of an uphill struggle for disabled students.

7.2 Negotiating Identity

“[Did you disclose?]”

“Yes as I strongly believe in equality...you have to believe that the system will work.” [Alison]

“[no] I was worried that I wasn’t going to get on a course because of it” [Sally]

As previously discussed, habitus is not fixed and is constantly developing depending on changes in external or internal factors and affecting change in the person’s self-identity (Bourdieu and Wacquant 1992:133; Hage 2013a). Starting at university is recognised as a major life event and certainly an external factor that will impact on identity. All students have to redefine themselves in this new environment; often leaving home for the first time, becoming independent and making new friends (Borland and James 1999: 97; Weedon and Riddell 2007). In addition to this disabled students have to decide whether to disclose their impairments based on an assessment of the advantages versus the disadvantages of disclosure (Rhodes et al 2008:387). For students on health profession courses this is particularly sensitive due to the influences of fitness to practise policies within the professional groups (see 8.3.2.2). The participant quotes above demonstrate differing stances in the decision on whether to reveal their impairment during the admission process: openness or withholding disclosure.

7.2.1 Openness

I suggest that Alison felt free to be open about her hearing impairment for two reasons, Firstly she has an affirmative approach to her self-identity. Secondly, her impairment is socially more acceptable with only her hearing aids showing difference from the corporeal standard. Conversely Sally, who has Rheumatoid Arthritis (RA) which is not constantly visible, chose not to disclose, based on a fear of rejection. Whilst openness might be associated with students, such as Alison, who have an affirmative approach to their impairment (Darling 2003), and Sally can choose to withhold disclosure due to her impairment being

less visible, other students have no choice in being candid due to the visible nature of their impairments and consequently non-disclosure is not an option.

This capability to conceal disability status was illustrated in a rewriting of “*The Class Sketch*” (The Frost Report 1966) from a disability perspective. The ‘higher class/status’ person was represented by a person with a hearing impairment, whose hearing aids could be concealed in their pocket; the ‘middle class/status’ person was performed by someone with a visual impairment, who could fold up their cane, and the ‘lower class/status’ person being enacted by a wheelchair user who could do nothing to hide their disability. However, Zitzelsberger (2005:397) suggested that this cloaking of disability limits cultural awareness of bodily difference reinforcing the corporeal standard. Thus people who normalise to society’s assumptions reinforce the doxa of disability and the misrecognition of the corporeal standard.

7.2.2 Withholding

Sally’s previous quote explained that one of her reasons for not disclosing her RA during the application process was as a fear of rejection due to the physical nature of her impairment. Bourdieu (1990b:69-70) described a “bodily hexis” which is the bodily posture and movement expected from a person within a specific situation, which is incorporated into a person’s habitus as a corporeal schema; Knowing what a body should look like in a particular social space (Allen 2004:493-4). Therefore, Sally’s fear of rejection may be based on her realisation that her condition could occasionally cause her difficulties in conforming to the physiotherapy corporeal standard.

7.3 The Physiotherapy Corporeal Standard

The presence of some ableist attitudes towards physical impairments was exposed in my previous research which found that whilst admission tutors were willing to accept students with hearing or visual impairments, they were more reluctant when considering physical and somatosensory (sense of touch) impairments (Opie and Taylor 2008:297). These findings are supported by the

responses to students with physical impairments in my current research: Sally and Hannah being subjected to physical assessments during occupational health assessments, Jackie having to withdraw from her course due to her acquired impairments, and Jane having to justify the efficacy of her treatment applications. I propose that the hierarchy of disability within the physiotherapy corporeal standard is focused more on physical capability rather than appearance; incorporating physical fitness, activity, somatosensory awareness, and manual dexterity (see 8.2). I feel that physiotherapists replicate this fantasy through illusion from four perspectives.

Firstly, our expert knowledge is derived from working on bodies (Nicholls and Gibson 2010:500), understanding movement at multiple levels (physiological, social and psychological) (O'Hearn 2002:5) and the symbolic importance of walking and gait re-education (Gibson and Teachman 2012; McKeever and Miller 2004:1185). Secondly, in our clinical work we incorporate social modelling (Bandura 1971:2) as part of the rehabilitation process e.g. demonstrating exercises. Thirdly, physiotherapists use their hands and sense of touch to assess and treat patients (Roger et al 2002; Öhman, Hägg and Dahlgren 1999:59) and therefore these abilities are highly symbolic forms of physical capital. Finally, the symbolic violence used to delineate therapists from patients, which maintains the professional distance with therapist as expert and disabled person as client (McKeever and Miller 2004:1179; Edwards and Imrie 2003:251). Physiotherapists misrecognise the notions of inability and dependence perpetuated by the doxa of disability, assuming that a physically impaired person would not be able to become an expert in movement; model movements to patients, or apply manual techniques efficiently and effectively due to a lack of corporeal attunement. Also the relationship between therapist and patient would be undermined if therapists did not conform to the physiotherapy corporeal standard. Interestingly, there has recently been an online debate about the reduction in "hands on" work within the profession (Chartered Society of Physiotherapy 2015a) and a presentation at the CSP congress by Owen and Kell (2014) who stated that the development of physiotherapy as a profession depends on the bodies of physiotherapists and the things they can do with problem solving being symbolised through "the medium of

hands". The conclusions from both suggest a tension within practice between adherences to manual techniques, which are not necessarily supported by evidence based practice, and a need to provide more cost effective treatments, which limit the time to apply these techniques. Possibly a move away from manual treatments will adjust the physiotherapy corporeal standard facilitating greater inclusion of people with physical impairments.

7.4 The Label of Disability

The other reason for Sally's non-disclosure of her RA was due to not identifying with the terminology used or with the label 'disabled':

"It [UCAS form] asks you 'have you got a disability?' and in my head I haven't! So I just put no" [Sally]

Sally does not consider her RA to be an impairment, and she does not classify herself as disabled. Sally only disclosed in induction week in response to a talk, which specified RA as a condition that was categorised as a disability. Sally felt that her lack of identifying with the idea of impairment or disability was because her RA was part of her lifestyle and she was able to manage it successfully so that it had a limited impact on her daily life:

"I know what's going to aggravate it and I know what to do".

The use of terminology on the UCAS forms has been identified as being too narrow and limited without categories for long-term conditions, such as RA (Boyd 2012: 459), although it does included dyslexia.

Whilst Sam formally disclosed in documentation, he maintained a silence about his dyslexia during interactions:

"Not unless I had to! If there was a form...I put it in" [Sam]

He repeatedly described being embarrassed by his dyslexia and not engaging with the support provided for him during his schooling: *"Keeping it at arm's length"*

In both Sam and Sally's situations they display a lack of incorporating their impairments into their self-identity. In fact, the majority of the students within this project either did not associate with the idea of disability or only accepted it as a label applied to them by the majority group. Watson (2002) discussed the reflexive construction of self, giving the person the choice to include or exclude traits. His research findings are similar to mine, with only three out of fourteen participants incorporating their impairments into their self-identity. The majority of his interviewees rejected disability as a component of their identity by reconstructing the concept of normality. From a social constructionist perspective this response demonstrates internalised oppression: the misrecognition and symbolic violence within the general doxa of disability. Alternatively, if we considered this response from a social relational perspective, employing Darling's (2003) disability orientation I suggest that most of Watson's participants, like the students in my study, were positioned in the normalisation group. Only Alison demonstrated an affirmative approach, whilst Hannah shows a situational identification, stating that her identity was composed of student and athlete 95%: disabled 5%. Here she acknowledges that in specific situations different aspects of her identity are foregrounded, indicating fluidity of her self-identity. Watson (2002:521) supported this analysis by suggesting that his participants have moved from a "position of difference" to one where they "recover the self".

In Bourdieusian terms, this could be seen as rejecting the symbolic violence within the doxa of disability by rejecting the label of disability and the misrecognition of the need to create dichotomous groupings of people such as 'normal' or 'disabled'. So rather than a need to assimilate to one group or another the students are choosing to disregard disability as an important factor in the composition of their habitus. This supports Hage's (2013a) discussion that habitus, and consequently, self-identity, is an active, creative process where the external influences are combined with biological capabilities, including individual personality. I suggest that this is what results in the different orientations described by Darling and represented in my findings. As with other psychological strategies some might be categorised more positively than others, but none are invalid.

7.5 Reaction of others

One concern that a number of students shared was about the response of other people to their disclosure, either because of a fear of discrimination (see 8.4.1) or the underlying negativity of the doxa of disability:

“It’s just not understood... people have preconceived ideas of what might happen or what you might do”. [Victoria]

This demonstrates the dilemma faced by students, particularly those with a history of mental ill-health. Victoria decided to share information with academic and clinical staff, only once she was accepted on a course:

“...you have to explain your circumstances...only on a need to know basis” [with disclosure being related to] “legal or safety reasons” [Victoria]

However, she chose to maintain her privacy from her peers explaining this decision by discussing the lack of understanding of mental health in the general public. Brunnberg (2010:180) discussed negotiation of identity occurring in two planes: vertically, with people in authority, and horizontally with peers. Victoria recognised the need for vertical disclosure, but maintained confidentiality at a horizontal level. The concern about reactions of others to the disclosure of mental health issues was reported in a study by Venville, Street and Fossey (2014) who found that the majority of their participants preferred not to disclose citing avoidance of stigma, discrimination, and the reaction of others, but also to indicate self-reliance and maintain privacy. The physiotherapy corporeal standard includes traits associated with mental wellbeing such as being competent (Öhman, Hägg and Dahlgren 1999:64) and hardworking (Cromie, Robertson and Best 2002; Cardiff university 2015). These are not usually attributes which are associated with people with a history of mental ill-health and negative reactions to health professionals with mental health issues may be couched in terms of fitness to practise policies and health and safety legislation.

Similarly, Hannah was anxious about the reactions of others due to the fluctuating nature of her condition:

“if I have a flare up and I’m off my legs, what are people [student peers] going to think?” [Hannah]

This concern about the perceptions of other people again originates from the negative doxa of disability. With this general negative background it is understandable that Hannah should be apprehensive of the reactions of her fellow students to a sudden deterioration in her mobility which accompanies a ‘flare up’:

“I thought people were going to think I was a bit of a hypocrite, the fact that I was training fulltime and doing uni, but then needing time off for illness” [Hannah]

A number of authors (Cross 2013; Goodley, Lawthorn and Runswick-Cole 2014; Runswick-Cole and Goodley 2015) suggested that the perceptions of the general public towards disabled people have become more negative since the recession began; Government austerity measures and television programmes such as *‘Benefit Street’* demonising benefit claimants, including disabled people. Consequently, disabled students in future may be even more reluctant to disclose.

HCPs’ views of disabled people are comparable to those of the general public (French 1987) and therefore Sally’s fears were not unfounded. She realised that the fluctuating nature of her condition can be confusing and factored this into her decision-making about horizontal disclosure. People with long-term conditions, which have changeable presentations, have recently become the focus of research. Boyd (2012:460) and Vick (2013:177) claimed that episodic conditions are met with scepticism or suspicion by others, due to looking well, yet reporting disability. Students with these types of conditions may find it difficult to assimilate into both the ‘normal’ and ‘disabled’ groups: living in between illness and wellness (Vick 2013:179). I propose that this research illustrates how the juxtaposition of being visibly identifiable with the corporeal standard, yet reporting a deviance from it creates a dilemma for the other person trying to categorise the students. ‘Normal’ and ‘disabled’ are oppositional concepts so these students do not fit into either group, being rejected by members of both: not fully ‘able’ for the

first, and not really 'disabled' for the latter. Thus students with fluctuating conditions may be demonstrating internalised oppression of this misrecognition with a normalisation orientation (Sally), or they may be situational identifiers (Hannah) with fluidity to the self-identity allowing them to choose whether to disclose depending on the specific circumstances at the time (Darling 2003).

7.6 Changed identity

Three students had their disability diagnosed whilst on the physiotherapy course, two of them (Lauren and Jane) were diagnosed with specific learning difficulties and Jackie had a motor cycle accident. Whilst all three of these students had to cope with a change in their identity, it might be suggested that the label of specific learning difficulties was advantageous. Up to this point, Lauren and Jane had been struggling on the course, within university:

"I was overwhelmed with the amount of information that we had to learn and that I just physically wasn't learning it...I tried so many different ways of trying for this information to go in and to understand it... I just felt frustrated that I could see that people around me were getting it and I wasn't." [Lauren]

And clinical placements:

"I suppose it kind of finally came to light when I went onto placements when I was having to work under pressure: remember arterial blood gases, different values and that sort of thing." [Jane]

Both of these students discussed self-doubt of their abilities and indicated a certain level of relief once they received a diagnosis:

"I think really just knowing that there was actually ...a diagnosis rather than people thinking I was just being stupid or lazy or both, made it a lot easier ...and I think that obviously improved my confidence and stopped me getting stressed and everything else became a lot easier" [Jane]

"...because I have a difficulty, I'm almost pushing myself, this has shown me I need to ask for help. And, I feel maybe there's been a bit more assistance I can't quite explain it really. People are almost happy to help" [Lauren]

Jane and Lauren found that this new disabled identity gave them more confidence to seek help and more opportunities for help from tutors. I propose that this change in attitudes reflects the physiotherapy doxa of being competent. Struggling students are seen as not fitting this model and, although they do receive help this is limited by the competent image, which becomes adjusted slightly once a student receives a diagnosis. Jane and Lauren's changed habitus gave them new strategies and capital, as both spoke of an increased confidence in seeking support. Jackie's situation is discussed later in this chapter.

7.7 Continued negotiation

In summary, identity is not a fixed constant; it is dynamic, influenced by internal and external factors. Hage (2013a) stated that habitus is a creative process where agents internalise external factors and combine these with their internal biological capacity, creating an evolving habitus. Throughout their courses the students were faced with decisions to extend vertical disclosure to the whole academic staff, clinical educators, visiting tutors, and, in their final year, to the CSP, the HCPC, and prospective employers. However, the reluctance to perform horizontal disclosure remained. Students, such as Clare and Alison, had visible representation of their impairments and therefore this horizontal negotiation was affected by these, but the other students who had hidden or fluctuating impairments were able to limit the exposure of these to close friendship groups. The experiences encountered in response to disclosure framed their future decisions (Venville, Street and Fossey 2014:799). Most of the students in this study had positive experiences to both vertical and horizontal disclosure; the exception being students with physical impairments who did not conform to the physiotherapy corporeal standard.

When planning for their first qualified position the disabled students again had to consider how open they wished to be with prospective employers. Many students discussed this as a dilemma; they may have had positive experiences during their course but had anxiety about potential discrimination in the job application and fitness to practise (see 8.3.2.2). Students had competing imperatives: they wished to uphold professional integrity yet maintain privacy and

avoid discrimination. However, most of the participants' decided to disclose their impairments on job applications, stating that this was linked to professional integrity, which is a core value identified in the CSP physiotherapy Framework (Chartered Society of Physiotherapy 2013). Conversely, disclosure of disability on most job applications guarantees the applicant an interview. Therefore, the students' habitus might dispose them to declare a disability to increase their chances of getting an interview in the competitive employment market. However, Victoria was reluctant to accept this strategy, preferring to consider that she got her job based on her professional merit.

7.8 Development of Capital

The participants in this project possessed different forms of capital in varying amounts. They utilised their individual distribution of capital to gain entry to the profession and then to create a position within the professional field. The establishing of position is a relational process, again negotiated vertically, with qualified staff and governing bodies, and horizontally, with student peers. In this section I consider the following forms of capital which the students possessed and used to contribute to their success during their physiotherapy education: social, which are resources linked to social status and networks; economic, including financial and other assets that students use to help them succeed; cultural, comprising attributes that give the student a 'feel for the physiotherapy game' including accrual of information and qualifications, and symbolic, involving attributes significant within the physiotherapy field.

7.8.1 Social Capital

Physiotherapy students come from a variety of backgrounds now due to the widening participation agenda within HE, which requires the reduction of barriers for underrepresented groups (Botham and Nicolson 2014:461). However, there is still a greater representation of middle class, white, females within the profession (Öhman, Hägg and Dahlgren 1999:59) which is mirrored within my participants: nine females and only one male, with the majority of them being from socioeconomic group level four or above on the National Statistics Socio-economic Classification (NS-SEC) (Office for National Statistics n.d.). Bourdieu's

theory of practice (1990a:132) proposes that the exposure to these socioeconomic circumstances becomes incorporated into a person's habitus and guides their trajectory: their social capital is misrecognised as being the natural order affecting their strategies and actions to reproduce this situation. Therefore, it is not surprising that students from a middle-class background, regardless of any disabled identity, should plan a career in a profession, such as physiotherapy, to maintain their social status with support from their families. Nevertheless, once the concept of disability is added to the equation, a professional identity is still aspirational. The findings from my research show that the participants valued social support from their families (appendix Q), which helps them to achieve their career goal – it gave them social capital at the commencement of their professional journey. Allen (2004) conducted a Bourdieusian analysis of the experiences and aspirations of children with VI and their families (44 participants). The analysis identified that middle-class parents and children engaged in strategies that managed the embodiment of their impairments, by corporeal attunement, to enable them to maintain their social position and expected the child to occupy the same social space via participation in professional work.

Professions are also a portal to membership of a group with a higher social status than membership of the group 'disabled' or 'generic student'. This links with the hierarchy of disability already discussed, but also with social group theory (see 4.5.2.2). Bourdieu (1990a:75;1984:136) agreed that strategies of reproduction within a class or group were synonymous with social group theory where agents gain status from membership of groups, often at the expense of lower status groups. As previously mentioned, Hannah divided her persona into percentages identifying mostly with student and athlete rather than disabled person. When this idea was posed to the other students they mostly agreed with a higher identification of physiotherapist or student, rather than 'disabled'. This identification with the label physiotherapist could be argued to be a desire to gain greater social capital. However, it is also a shared goal of all physiotherapy students and therefore the students in my projects are not demonstrating difference but a common interest of achieving a shared goal.

7.8.2 Economic Capital

Economic capital refers to financial resources, but also to attributes that give the agent the potential of gaining financial rewards. One of the main attributes most commonly identified as a category in the analysis (Appendix Q) was determination to succeed. As previously discussed being hard working is an attribute associated with the physiotherapy doxa therefore, it could be argued that all physiotherapy students need to be determined due to the expectation of hard work from the outset of the course (Cardiff University 2015). However the students involved in this project felt that students with a disability needed to be even more determined than other students, to prove themselves or to overcome discriminatory comments or attitudes. This determination is needed initially in selection of physiotherapy as a career, to defeat the devalued image of disabled people that resides in the general doxa of disability (Olney and Brockelman 2003: 35; McKeever and Miller 2004:1178). Alison and Clare both received negative responses from school when they indicated their interest in physiotherapy as a potential career. Whilst Sam was advised not to compete with his older brother by his mother:

“I’d hate that! I did get a bit frustrated, or feel rubbish, when Mum or Dad would say stuff like that” [Sam]

The teachers and Sam’s parents may have expressed their doubts based on altruistic sentiments, wanting to save their pupil/child from rejection. However, it may conversely be based on the symbolic violence towards disability and the deep seated misrecognition of disabled people being unable to compete and function at this academic level.

During their courses the students still require determination to manage the amount of work required of them. Although all physiotherapy students work hard, my participants felt that they needed to expend greater effort in both university and clinical components of the course. Lauren very eloquently, described the effort required from her in completing her physiotherapy degree:

“it feels like I’m putting in 150% plus!...as if I’m climbing Everest – and in bare feet”[Lauren]

Interestingly, when I mentioned this metaphor with a physiotherapy educator colleague I triggered the misrecognition that this was expected and all physiotherapy students should work that hard. On deeper reflection I realised that this metaphor did not denigrate the efforts of all physiotherapy students, as my colleague had assumed, it recognises the hard work of all students; they are all climbing Everest, although some of them have to exert more effort: in bare feet.

This led me to research Everest, which further deepened the analogy (see figure 7.1). The majority of physiotherapy students are following a well-trodden path, whereas disabled students may be the first student with a specific impairment to apply to a physiotherapy course. The many Everest tourists follow the slightly easier south-eastern path (the route used by Mallory and Sherpa Tensing Norgay), whilst the other popular route is the harder north ascent.



Figure 7.1: Analogy of physiotherapy course to Climbing Everest

Although the physiotherapy course is hard work, for non-disabled students they are in a safe environment with appropriate resources and sharing this experience with a group of similar students. Conversely, disabled students are in a minority, possibly being the only person with that impairment on their course. They are in a setting which does not necessarily cater for their needs, requiring assistance to obtain resources and support to help them conquer this hostile environment. The south-eastern path leaves from Nepal and is so popular there are permanent camps and climbing equipment for the climbers. At times there can be as many as 500 people at the summit (spring 2012). However, the north col, which starts in Tibet, was traversed by only one quarter of the total assents in 2012, being less popular it may be just the climber and their Sherpa undertaking this assent (Jenkins 2013). This extra effort and need for determination from disabled students to negotiate both identity and learning support is documented by many authors since the introduction of the DDA 1995 to the present day (Fuller *et al.* 2004:313; Holloway 2001:600-602; Olney and Brockelman 2003:43-4; Tinklin, Riddell and Wilson 2004:649; Weedon and Riddell 2007). Coincidentally, Riddell (1998:211) also used the analogy of a mountain in her article about the experiences of disabled students in higher education. This article examined the policy and practices within HE in Scotland compared to findings of disabled students experiences. Disappointingly, although the article is nearly twenty years old the issues it discussed are still relevant in 2015 and in parts the article has proven to be prophetic when discussing the possible future “policing” of the boundaries of the label disabled (see 8.3.1 and 9.4.2).

Even with this high level of determination some students fail to complete the course. Although very well supported by her course and husband, Helen withdrew from her degree after the first term as she could no longer cope with the demands. Reflecting on her decision-making process she felt that the initial difficulties she had in arranging the Disabled Students Allowance (DSA), lack of time for training on the equipment, coupled with spending the whole weekend printing off materials for the following week’s sessions was too much:

“I was putting in 100% ...on the course and at home...even with all the effort and the time ...it wasn’t enough!” [Helen]

Jackie on the other hand, another very determined person, found the lack of support she received in response to her acquired disability in year two of her programme very frustrating. She sought advice about fighting the university’s decision to withdraw her from her course, but was very disillusioned when she kept having the Health and Safety Act 1974 cited as a reason for her exclusion. In the end she decided that she needed to take stock of her situation:

“so I thought...I’ve got to step back and think whether or not this is a good way to be spending my time and energy...you’ve got to pick your battles that are going to resolve in a positive way”.[Jackie]

Both Helen and Jackie decided that, even with their determination, the effort was too demanding. Some of the other students (Hannah and Lauren) discussed that their determination and hard work for coursework often achieved a lower grade than other students. Pumfrey (2010) and Weedon and Riddell (2007) compared completion statistics for disabled students with those of the overall student population and found that whilst the completion figures were relatively similar less disabled students got a first class degree, being more highly represented in the unclassified degree banding.

7.8.3 Cultural Capital

Cultural capital is best described as the way in which the student’s habitus gives them a feel for the game. When we move into a new field we need to acquire cultural capital. One influential form of cultural capital is a formal qualification (Bourdieu 1990a:136), for physiotherapy education the minimum qualifications are set within level 3 of the Qualifications and Credit Framework (Accredited Qualifications 2012). However, mature students do enter the profession with higher qualifications than this. Within this project six of the participants possessed prior experience of university and thus cultural capital of HE. The possession of this educational knowledge should have given them a better feel for the academic game than other students. However, the remaining four students had prior experience of the healthcare system; one was a military

paramedic and the other three had at least one parent who was a HCP. Therefore, whilst they lacked cultural capital with respect to HE, they enjoyed a level of cultural capital within the health field.

Even though the participants possessed different levels of cultural capital they reported similar anxieties and concerns about starting on their physiotherapy course:

*“I suppose [I was] a bit apprehensive as to the demands of the course”
[Helen] (Chemistry degree)*

“but everyone is in the same boat, everyone’s come from different backgrounds and they will have problems within themselves, because obviously no one is perfect, and everyone does have their worries. So no, I don’t think I am unique in being the only one that worried and had difficulties at the beginning”. [Clare]

The consensus of opinion was that their status, as disabled students, was no different to the status of students without impairments; all students have a mixture of excitement, apprehension and anxieties when starting at university. For mature students this might be around being the only older member of the student cohort, whilst younger students are worried about leaving home for the first time. Disabled students might be anxious about how their impairment will affect their coping at university, whilst non-disabled students might be worried about making friends and fitting in. Bourdieu explained that a person’s sense of the game increases the longer they are immersed in the field (Wacquant 1992:24). In this respect all new entrants to a physiotherapy course, regardless of their age or disability status, are at the same position: novice (except possibly a student who has a physiotherapist as a parent, or a mature student who had been a physiotherapy assistant). I suggest that this novice status is the overriding factor as far as physiotherapy tutors (both academic and clinical) are concerned causing them to treat all students the same regardless of prior HE or health experience. HE experience is disregarded as physiotherapy is perceived as a harder degree than any other; similarly prior health experience is disregarded if not within the physiotherapy field.

Social skills, such as interpersonal communication skills, might also be seen to confer cultural capital within both HE and healthcare. In HE these are viewed as transferrable skills and are developed on most degree programmes to improve the employability of graduates. Within healthcare these skills are essential for high quality patient care and therefore applicants for HCP degrees are expected to display good interpersonal skills and students are selected on these factors. Therefore, these become symbolic capital within the field of healthcare.

7.8.4 Symbolic Capital

One form of symbol capital that is currently very highly valued within the field of healthcare is empathy. Since the Francis Report (Francis 2013), compassionate health care is emphasised and admission tutors are being encouraged to screen for empathy, care and compassion during the admission process as values based recruitment (Health Education England 2015). Within this study the participants highlighted their perception that they had high levels of empathy with their patients. Clare discussed the empathy she gained with patients with a hearing loss:

“it's a much older population, and a lot of them have hearing aids. So when they see you've got a hearing aid, that's something we've got in common... I think they start to feel that you might have a bit more of an understanding of where they're coming from... In that sense it's quite positive.” [Clare]

Whilst Alison spoke of the visibility of her hearing aids making a connection with patients who had a physical condition:

“I think having a disability has made me more aware not to take things for granted and that's something that a lot of patients say to me especially stroke and amputees and they can see that I have a disability and feel I'm not patronising them as I'm not fully "perfect" in their eyes, so they learn to trust me quickly.” [Alison]

Sally discussed how her lived experience of RA could be used to help support other people with the same condition:

“If I was to work with rheumatology patients then I would have a better understanding of where they’re coming from” [Sally]

also Victoria perceived that she had developed a higher level of holistic care for her patients:

“I think that’s possibly one of the advantages of having had some ups and downs myself is that you know they might have a problem with their hand or their knee or whatever, but they’ve got other stuff going on as well, and OK, you’re not there to treat that, but it’s taking consideration of other things that are going on”
[Victoria]

In fact, Victoria reported that clinicians were suggesting that she might be too empathic!

“my last placement ...their comment was...my empathy was brilliant... but the downside of that is then not getting them to do what they needed to”. [Victoria]

In response to these comments I conducted the systematic meta-synthesis described in section 5.4.3.4. The synthesis of the review supports the concept of increased empathy between disabled HCPs and their patients, identifying four main themes which correspond to the four categories of empathy proposed by Morse *et al.* (1992) (Table 7.1). The impact of impairment for the HCP gives them a subjective experience of disability (emotive empathy) that non-disabled therapists lack. This enables them to understand the patient’s perspective better, informing their own practices, and potentially the practice of other HCPs (cognitive component), allowing them to demonstrate empathy (behavioural component). However, morally, any sharing of personal information must be in the best interests of the patient rather than for self-gratification of the HCP. Opie and Parkes (2015) have suggested that these findings are important for the education of future HCPs, a concept that fits with French and Swain’s affirmative model of disability (2004). From a Bourdieusian analysis the experiences of disability encountered causes an evolution in the person’s habitus giving them new strategies and capital to use in their practice.

Theme	Category	Component of Empathy (Morse et al. 1992)
Impact of Impairment	On self “I began to realise that the overall depression wasn’t going to go away...it would always limit me.” (Hilfiker 2001)	Emotive Empathy
	On professional identity “I always reckon that my reputation is worth more than secrecy.” (Gaze 2003)	
Disclosure to patients	What to say? “I am telling you because I may sound a bit slurred, and if I do it is not because I have gone out for a quick one!” (Gaze 2003)	Moral Empathy
	Appropriate? “I do [talk about his impairment], but only when I feel the time is appropriate.” (Maughan 2005)	
	Patient Initiated “When asked by a patient ‘What have you done to your arm?’ I often reply ‘Oh! Far too much’ and then change tack.” (Maughan 2005)	
	Patient Reaction “That’s cool, Doc! We’ve been noticin’ something wrong. You just take as much time as you need. We’ll be here for you.” (Hilfiker 2001)	
Empathy	Experiencing empathy “She connected with my fear of losing everything to cancer.” (Elmore 2011)	Behavioural Empathy
	Response to empathy I felt reassured when I could trust someone and know they understood my concerns, even if they couldn’t solve them.” (Lyll 2010)	
	Absence of empathy “What I actually got was one counsellor telling me I needed to talk to myself the same way I talk to my dog.” (Weiss 2001)	
Informing practice	Own practice “Talk to my patients. Talk with my patients. Explain carefully....smile, touch a shoulder.” (Andrus 2007)	Cognitive Empathy
	Education “How ...do you combine the heartsickness of humanity with the mental acrobatics of medicine, when both are required to be a good doctor and only one is reinforced?” (Elmore 2011)	

Table 7.1: Themes and categories generated in review with Morse’s categorisations of empathy.

The HCPC and CSP representatives gave mixed responses to this concept of disabled HCPs expressing greater empathy; whilst agreeing in general with the hypothesis :

“this is a very personal view, but it is about being able to better understand and from a patient’s perspective” [CSP #1]

“where people have personal experience of disability they really enhance understanding for their patients and they have a different perspective” [HCPC #2]

They amended codicils, firstly about the dangers of homogenisation:

“it’s a slightly risky strategy, because it’s kind of making generalisations potentially, every disabled individual is different...sometimes it can work in reverse: ‘I’ve got, [or] I’ve dealt with this and that and I can’t see why you can’t!’” [CSP #2]

“I have a slight difficulty with the question in that there’s a sense in which you then lump everybody who has a disability together” [HCPC #2]

But also of the possibility of discrimination against non-disabled therapists:

“I suppose you wouldn’t want to get to the situation where it’s almost if you have a disability you’re at an advantage to someone who’s able bodied who doesn’t also have kind of qualities that they can bring as well” [HCPC #1]

This final comment demonstrates the symbolic violence and misrecognition against disabled people; it being inconceivable that they might be at an advantage over non-disabled people at any point.

Increased empathy with patients is not the only symbolic capital that disabled students can employ; they can also take advantage of their impairment in their positioning within the physiotherapy field:

“I did find a lot of educators or physios who were speaking with patients who are hard of hearing; they would then look to me to translate”. [Clare]

“I’ve found that my disability has proved very useful in situations with patients, in particular on ICU, as I can communicate with intubated patients via lip reading which both staff and patients found very beneficial”. [Alison]

Jane discussed how her problems with hand eye co-ordination made patients with stroke less self-conscience:

“I think they felt not ‘as on the spot’ when they were doing it either, because I think if they saw you dropping it and having to go over and fetch it then I think they felt a bit better about themselves as well” [Jane]

The value of embodiment has already been discussed, but it is essential to indicate the importance of physical capital within the physiotherapy field. I submit that the physiotherapy corporeal standard is the most important symbolic capital in the profession. However, the comment by Jane implies that the physiotherapy corporeal body might be a barrier when working with patients with a disability; the perfection of the non-impaired body rather than being a social modelling asset may actually be acting as symbolic violence against these patients. Therefore, contrary to the earlier discussion of embodiment, therapists with impairments are an asset to the profession.

7.9 Negotiating Learning Support

Negotiation of learning support for all students begins with the selection of university and considering whether the institution will support their individual learning needs. The strategies adopted by the participants in choosing their university were the same as those chosen by non-disabled students; concerned with researching the reputation of the university/ course and logistical issues. This is not surprising when you consider that most of the contributors did not perceive themselves to be disabled. In this technological age, websites are often the first port of call for gathering information. Most of the participants reported accessing sites on the internet such as NHS careers, CSP, UCAS, and specific university websites. None of the disabled students visited the HCPC website, a finding replicated in the research undertaken for the HCPC in preparation for rewriting their documentation (Clouder *et al.* 2013).

7.9.1 Accessible Information

There is an assumption that information placed onto a website makes it accessible, although some of the participants found it difficult to discover this information:

“I did struggle a bit... it was quite difficult to sort out and get through to it. Whereas you think... you’d have a link ...saying disability support.” [Hannah]

“you know it’s like the standard thing tucked on at the end” [Victoria]

A number of authors discussed the fact that websites are not particularly accessible for disabled people, but from an interaction with the sites perspective, rather than the ease of locating of information (Adams and Kreps 2006; Curran, Crawford and O’Hara 2004; Gerrard 2007). In response to the participants’ comments, stage two of the research incorporated a survey design, using two non-physiotherapy undergraduate students as research assistants (see 5.4.4).

University	No of Clicks	Is it useful?	What information (student #1 student #2)
Cumbria	4+	Yes	Help with coursework and assessments, give access to specialist tuition. Can be hard to initially find the information
Birmingham	2 15	No Yes	Just information about disclosing your disability and DSA. General information on disability and specific dyslexia support
Hertfordshire	3+ 9	No No	All information is not together General information only
Cardiff	3+	Yes	A lot of information all linked mainly through one page, but can take a while to find the information you want. Provides individual information for students with an array of different disabilities
Huddersfield	2	Yes	All information is accessible from the one page including a video interview with a disabled student
Nottingham	2	Some	Have own disabilities booklet and admissions policy for disabled students
Sheffield Hallam	4 9/11	Yes Yes	Specific information, but doesn’t take you to all of the information 9 clicks – basic information 11 clicks more specific dyslexia and visual impairment information
Manchester Metropolitan	3	No	Not easy to find and there is not a lot of information available. Some guidance for students with specific disabilities
Coventry	9 14		General disability information More specific information although this was not helpful regarding dyslexia or Irlen’s.
Kings college London	9	No	Basic information only

Table 7.2: Findings on Accessibility of Information on Support for Disabled Students Considering Physiotherapy as a Career.

The students found that most of the information available on websites was generic information (table 7.2) with little or no disability information via the physiotherapy course links. They also documented, like Hannah, that the information was not easy to find taking an average of 3+ (student 1) or 11 (student 2) clicks to access all the information. The 'three click rule' is an apocryphal concept which states that people exit websites if they do not find the information they are seeking within three clicks. However, Porter (2003) studied this idea and found no correlation between the number of clicks and consumer dissatisfaction. He identified that frustration was associated with the time taken to access information rather than the number of clicks.

My findings indicate that the institutions were responding to the Equality Act 2010 in an administrative process, rather than an inclusive manner. The Act recommends the use of the internet for dissemination of websites, and there are computing standards for accessibility of this information (Adam and Kreps 2006:205-6). However, it would seem that there has been little consideration of the ease of gathering this information, as experienced by my research assistants. Information is available in many different areas of the websites, sometime with no logical route to finding it. This is maintaining an environmental barrier for disabled students and a demonstration of symbolic violence, suggesting that disabled students are not necessarily welcome. It would be preferable for generic disability information and specific faculty and course information to be accessible through a specific disability link chain (see 9.5.2).

Another issue raised by a participant was not just the ease of finding information, but also the nature of the information:

"it wasn't the fact that there was anything out there that was negative... it was the fact that there was nothing out there to make you think that it could be sorted and would be alright" [Hannah].

The lack of a positive, affirmative perspective for disabled applicants caused Hannah to withhold disclosing her impairment until she was enrolled on her

course. Many of the participants recommended improvements of the information available for prospective applicants, which included higher visibility of information on the internet (see 9.3). Visibility of disabled students on university websites and in prospectuses was analysed by Collinson, Dunne and Woolhouse (2012: 864-8). They found that whilst the resources responded to legal requirements information was presented in a “paternalistic theme” of dependence or “absence as recognition” using logos rather than photographs to represent images of disabled students and segregated to a special section. In fact, the UCAS (2015) webpage for disabled students has a short four minute video about applying to universities. The only person in the film with a visible disability was a wheelchair user who appeared on screen, in the background, for approximately three seconds. The majority of the film could have been used to show university life in general rather than for disabled people. Nevertheless, it did conclude with a student talking about the support she has received for her dyslexia. This could be critiqued as recognition by absence, focusing on people who do not display any visible representations of impairments, or it could be viewed as attempting to decrease the emphasis on difference, promoting an inclusive community which values diversity. However, it does not portray the affirmative information that Hannah requested. It failed to demonstrate that disabled students were present at the university and succeeding. I suggest that this film clip demonstrates universalisation; the application of the corporeal standard and a normalisation orientation to disability.

7.9.2 Assessment of Need

One important piece of information that disabled students require is how to apply for the DSA, which is used to finance reasonable adjustments. In order to get maximum benefit, these adjustments need to be in place for the beginning of the academic year. Seven of my participants were aware of their impairments prior to attending university, but only three of these applied for their DSA prior to starting at university. Ideally, the students should submit a DSA application in the academic year prior to their commencement at university (UCAS 2015). Previous research into HE in general highlights this extra preparation that disabled students have to undertake during the transition to HE (Fuller *et al.* 2004). Viney

(2003) suggested that students start applying for DSA as early as possible as it can take up to six months to complete the process.

Helen, who has a visual impairment, was acutely aware of the need to get her support package in place before the commencement of her course. She held an unconditional offer and applied for her DSA and needs assessment in the spring/ summer before her course started. Unfortunately there were problems with this resulting in her support being delayed. Once the equipment arrived she had to learn how to operate it alongside completing the studying required for the course. This contributed to high stress levels and a feeling of being overwhelmed:

“that was a real battle to have to cope with that. Well, not cope with it, but to have to deal with it: chase it up, wondering what’s going on, as well as trying to settle into the new course.” [Helen]

She felt she lacked the time to devote to learning how to use the new equipment alongside keeping up with the delivery on the physiotherapy course.

“even when I had the kit, I hadn’t got time to, ... it’s not an excuse, but to...teach myself that on top of trying to keep up to pace with the course, it’s not easy”. [Helen]

The problem with late applications is getting support systems in place soon enough to facilitate the student’s learning. However, as identified by Parker and Myer (1995), the NHS bursary unit is reluctant to release monies for equipment prior to the commencement of the course. This diffidence by the NHS to release the DSA monies means that all disabled students will be in the position of learning how to use their support package at the same time as adjusting to a new environment and learning new academic information. The delay between the needs assessment and the support package being in place is at least one month. Even if the students get their DSA and arrange their assessment in the first week of the academic year it could be the middle of November before they get their support package. Therefore, students will be completing their first semester at university with little or no support in place. If they do get the support at the start of the academic year, they will be trying to learn how to use the package

concurrently with their academic studies, as described by Helen, who found this dual-tasking a particular problem and was one of the contributing factors for her withdrawal from the course. I feel that this adds to the students' struggle to gain position within the field of physiotherapy. The delay in funding is another example of an environmental barrier from the NHS faced by disabled students. It is also an example of the symbolic violence against health professional students, putting them at an instant disadvantage, and potentially limiting them from displaying their capital on the course i.e. limiting their ability to perform to their optimum in any early assessments.

7.9.3 Support provided

Once support packages had been negotiated and were functioning most of the participants valued the support within the universities:

"I've been lucky in the amount of support I received from the university staff, both the physiotherapy lecturers and the disability staff". [Alison]

However, some of the participants found support on clinical placements less helpful:

"[clinical placement support was] poor I think is probably what I'd say, in terms of understanding: I don't think people quite have the understanding of how it varies from person to person". [Lauren]

"I think educators didn't really -- none of them really understood what my hearing impairment was. It's just not being afraid to keep nagging and keep reminding them that's how you learn. In some ways you feel like you're drowning a little bit"
[Clare]

This lack of understanding from clinical educators was echoed by other students in the study. It was also identified in previous research with physiotherapy admission tutors (Opie and Taylor 2008), in the teaching profession (Partington 2003, Tait and Purdie 2000) and social work (Baron, Phillips and Stalker 1996). Tinklin, Riddell and Wilson (2004:649) suggested that the success of disabled students at university was dependent on the negotiations that Clare describes above. They emphasised that the HE system has a

normative approach to supporting disabled students; although responding to the social model of disability, the overall practices are rooted in the individual model of disability with the disabled student having to individually negotiate their own support package to enable them to overcome barriers. The authors acknowledged that this makes life harder for the student; establishing balance between the competing necessities of assertion and assimilation.

Within physiotherapy the CSP discuss supporting student on clinical placements as a tripartite responsibility; academic placement tutor, clinical educator and student (Owen Hutchinson and Atkinson 2010:88). One of the key factors for facilitating good support on clinical placements is the sharing of information between these parties. Botham and Nicholson (2014) reported an action research project for implementing better communication and support for physiotherapy students on clinical placements. The project introduced a new procedure including a pre-clinical meeting where support needs were discussed and documented with the student's personal tutor. This documentation was then shared with the student and clinical placements to facilitate communication and improve support for the student. Auditing of this project demonstrated that the process worked well if the student declared and was in control. However, the very low response rates from staff suggested an institutional neglect of issues linked to disabled students. This indicates a level of symbolic violence against disabled students which I suggest is more widespread throughout physiotherapy education, than just the institution involved in this project, and is most strongly demonstrated in the response to Jackie's acquired injuries.

Jackie, after her motor cycle accident, underwent an intense period of confrontational discussions between herself and her course director, which did not go in her favour. She felt that the people in higher status positions within the field: the physiotherapy course tutors and representatives from the CSP, had closed minds with respect to her continuing on the course. She was willing to try, and possibly fail, to pursue her desire to be a physiotherapist, but the institutions

possessing the powerful positions within the field were not willing to support this and actively created barriers to preventing her continuing:

“they said it would make things complicated ...they started saying about having to start year 1 all over again to prove that I could pass year one in the wheelchair...it was as if every time I was talking to them about a solution I got ten more problems thrown at me” [Jackie]

The evidence used to support the course’s position was the Health and Safety at Work Act 1974 (HSE n.d.). The course claimed that her attendance on clinical placements would endanger the health and safety of patients and whilst within the university it would jeopardise the health and safety of the other students.

When she sought advice about her legal situation she was told:

“the only way forward was to get the ‘heavyweights’ involved to start forcing it and was I wanting to cause massive problems. I felt like I was gonna be bringing the name of the physio and university down if that makes sense” [Jackie]

This indicates symbolic violence not just from the physiotherapy course director involved, but also the advice from the CSP and the independent agencies that Jackie approached. The level of misrecognition against a wheelchair user being a physiotherapist is spread throughout the physiotherapy profession and also the wider community. I maintain that this is because a wheelchair user is unable to attune to the general and the physiotherapy corporeal standard, which is so strongly linked to movement and walking, as identified earlier (see 7.3). However, this is not an opinion held by one of the representatives from the HCPC:

“I think the important thing is, with the standards of proficiency, ... there is a degree of latitude there anybody coming to us saying you know ‘ I’m a wheelchair user, I’m a qualified physio, ...I can’t do x,y & z and therefore I always have a physio assistant ... she and I work together to deliver the intervention’. That would be absolutely fine”. [HCPC#2]

The application of legislation and policies occurs within physiotherapy education at the level of individual tutors on individual courses. Here people are more focused on the practical application of policies which is strongly influenced by the habitus of the person involved, which itself is manipulated by the social

structure. Therefore, misrecognition develops due to the iterative nature of this process: 'things have always been done this way'. Consequently, negative attitudes that existed prior to disability legislation are perpetuated within professional courses. This has two main consequences for disabled students; all students are expected to achieve competence in all aspects of physiotherapy practice (see 8.4.2) and the wording of HCPC competencies are interpreted from a physical capability perspective affecting admission and retention for students with a pre-existing or acquired physical impairment. Section 14 of the HCPC competencies (Appendix O) indicates the technical skills required of physiotherapy registrants. There are twenty three items within this section, eight of which include verbs that can be interpreted as linked to physical capabilities: deliver, use, undertake, apply, conduct, implement. It is my assertion that these verbs are being interpreted with a very narrow, physical capacity by most physiotherapists, due to the strength of the physiotherapy corporeal standard.

7.10 Summary

In summary, is it a level playing field, or an uphill struggle? Interestingly, the participants felt that they were different, yet the same as non-disabled students. Whilst they were concerned about managing their impairments, non-disabled students also had concerns. I suggest that this is a demonstration of the normalisation orientation posited by Darling (2003). I firmly believe that whilst it appears a level playing field on paper, in practice disabled students are definitely climbing Everest in their bare feet! This extra effort is required from disabled students at all stages of their career development in the interactions between disabled students and others in the physiotherapy education arena.

Whilst the transition to university has to be negotiated by all students disabled students have to expend more energy in these negotiations. They have to make conscious decisions about sharing information both vertically and horizontally within the field. There was a variety of approaches adopted by the students on self-identity and disclosing their disability status, most being open,

although somewhat reluctantly. Those that chose not to disclose did so either due to a lack of identifying with disability as a label or a fear of discrimination.

The students use strategies and capital to position themselves within the field of physiotherapy. Socially, the majority of the students fitted the physiotherapy doxa of predominantly female middle class individuals, whilst culturally they all possessed either prior qualifications or healthcare knowledge to assist their transition. Disabled students need a high level of determination (economic capital) to overcome the general and physiotherapy doxas, which both act as barriers towards the inclusion of disabled students into physiotherapy. They also need to be determined to stay the course; expending greater effort to achieve in comparison with many of their non-disabled peers. In the post-Francis era empathy is a symbolic capital, one that the participants used to great advantage with patients. Evidence suggests that disabled HCPs have a shared experience of disability that non-disabled practitioners lack, facilitating an increased empathic bond. Physical capability is also a symbolic capital within the field of physiotherapy, and some of the students did not attune to the physiotherapy corporeal standard, which created difficulties for them, especially Jackie.

Negotiation of learning support starts at the selection of the degree course within the gathering of information and applying for the DSA. Contrary to popular opinion, the internet does not always facilitate information exchange. This was particularly so for my participants and research assistants who found it difficult to gain information about disability support over and above the generic university wide information. Other environmental barriers to developing their learning support are the DSA application and the normative systems within HEIs. Once the support was in place some students noted a lack of disability awareness on clinical placements compared to the university. This lack of awareness has been identified in physiotherapy by other authors (Opie and Taylor 2008; Botham and Nicholson 2014) and in other healthcare education (Baron, Phillips and Stalker

1996). Regrettably, Botham and Nicholson (2014) suggested a culture of disinterest as being prevalent within the university and clinical placements.

Throughout this chapter I have demonstrated how the physiotherapy doxa, in particularly the physiotherapy corporeal standard is responsible for the misrecognition and symbolic violence which affects the integration of disabled students into the physiotherapy profession. This is most strongly directed at students whose physical appearance or capabilities do not attune to the corporeal standard; they do not embody physiotherapy. The habitus of physiotherapy academic and clinical staff is dominated by this doxa resulting in the implementation of legislation and policies by agents with an *illusio* to replicate the professional structures unchanged. This attitudinal barrier reinforces the environmental barriers already discussed.

Bourdieu (1977:3) explained that the dispositions people select are developed from their habitus, which is the embodiment of the structure of the field in which the person operates. Through studying these dispositions and practices the extent and doxa of the field becomes visible. The final findings chapter considers the extent and doxa of the field of physiotherapy education by examining the data from the interviews by the CSP and HCPC representatives and the documentary analysis of the policies which underpin the practices.

Chapter Eight: The Field of Influence: An Analysis of the Field of Physiotherapy Education.

[T]here is a need to open up admissions procedures so that suitably qualified people with disabilities can become health professionals.
(Shakespeare, Iezzoni and Groce 2009:1816)

8.1 Introduction

As I explained in chapter two, the doxa, or unspoken assumptions, of disability within the field of power, represented by the general society, are negative: disability is considered to be an individual tragedy with disabled people viewed as dependent, non-contributors who do not fit the corporeal standard. French (1987), and Atkinson and Owen Hutchinson (2005), indicated that these general attitudes towards disabled people are mirrored within the physiotherapy profession, whilst Botham and Nicholson (2014) suggested a culture of institutional discrimination within physiotherapy education. Bourdieu (1990a:80) explained that the doxa within a field is often codified in legislation and policy documents. These are often used by the privileged members of the field to maintain their dominance by using strategies which appear to be egalitarian (Bourdieu and Wacquant 1992:88). This chapter examines the field of physiotherapy education to establish if it too maintains the status quo by appearing to be open and welcoming to disabled students.

The structure of the field of physiotherapy education was discussed in chapter three as consisting of a number of agencies; the HCPC, QAA, CSP, and the NHS controlled by the Department of Health or the Department of Business, Innovations and skills (figure 8.1). This complex structure results in physiotherapy programmes being validated by the HCPC, CSP and QAA, whilst the NHS controls the funding of students via the LETBs, which also have an influence on programme delivery. Therefore, the physiotherapy programmes have to implement the HCPC and CSP requirements, but also be responsive to demands from the NHS. As I suggested in chapter three, this creates two paradoxes for the physiotherapists working with disabled students within education. Firstly, the

paradox of the perfect physiotherapist, based on the assumptions of fitness, health and hard-work, which are oppositional to the stereotyping of disabled people. Secondly, the paradox of supporting disabled students, whilst maintaining professional standards.

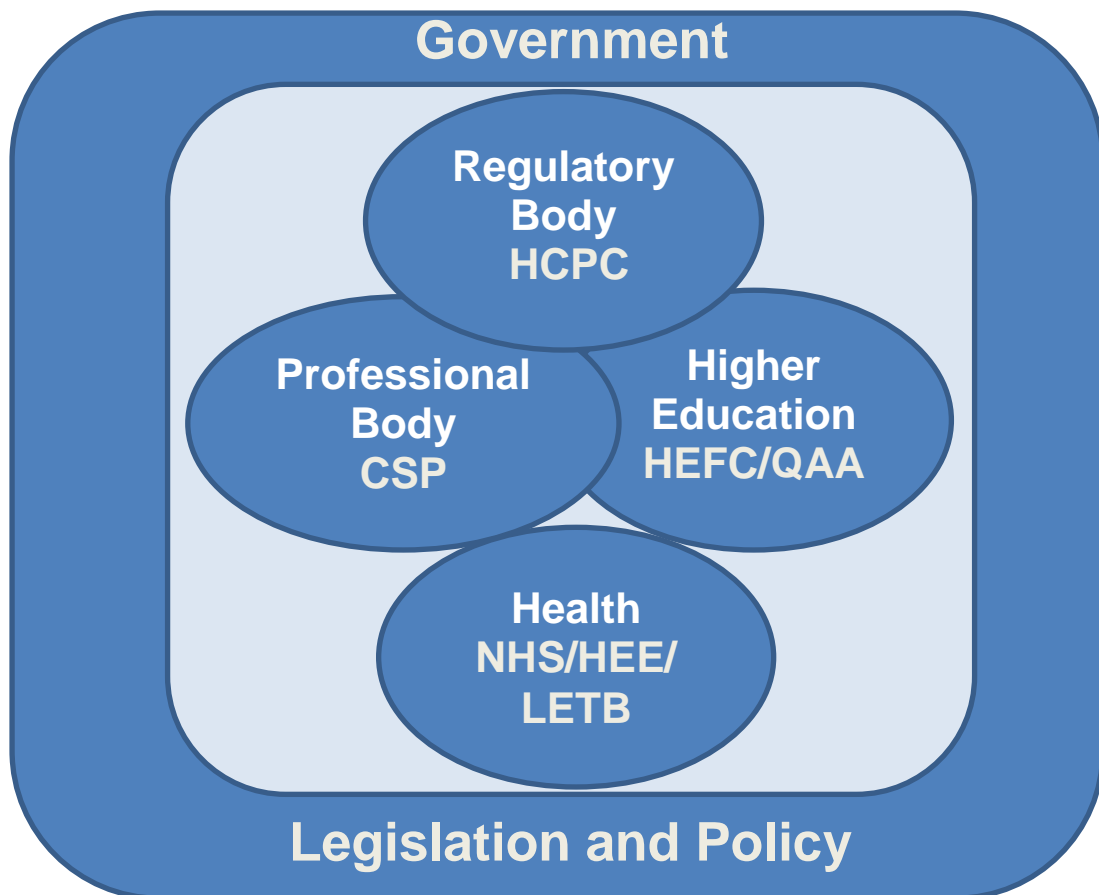


Figure 8.1: The Field of Physiotherapy Education

This chapter explores these paradoxes, firstly at a theoretical level by using data from the documentary analysis of the policies and the interviews from the representatives of both organisations; and secondly, from a practical perspective by considering the practices within the profession as experienced by the student participants.

8.2 The Paradox of the Perfect Physiotherapist: The Doxa within Physiotherapy

Whilst the doxa about disability has an impact on the way in which disabled people are perceived within society in general, for disabled students applying to physiotherapy this is reinforced by the doxa of the 'perfect physiotherapist' working alongside the physiotherapy corporeal standard. This creates more environmental and attitudinal barriers that disabled students have to negotiate in order to pursue their career ambitions. The explicit requirements for a physiotherapist are codified within the HCPC standards of proficiency: competencies (Health and Care Professions Council 2013); HCPC standards of conduct, performance and ethics: fitness to practise (Health and Care Professions Council 2012a); CSP codes of professional values and behaviours (CSP 2011); CSP physiotherapy framework (2013) and the QAA physiotherapy benchmark statement (QAA 2001). However, the unspoken doxa and symbolic capital within the physiotherapy field will affect the manner in which the codified expectations are interpreted. This section examines the objectivity of the codified standards; considering their impact as environmental barriers towards disabled students. It is important to note here that the mapping of impact on disabled people (appendix O) is an analytical exercise to assist with discussion, and not for any purpose of recommending inclusion or exclusion of groups of students just because they carry a specific label. In the practical consideration of student applicants it is essential to consider each person as an individual. Subsequently, the hidden doxa will be exposed showing how this underpins the philosophy of physiotherapy; influencing practice, behaviour, attitudes, and recruitment of students.

In stage three the documentary analysis of the HCPC standards of proficiency (Health and Care Professions Council 2013), the CSP codes of conduct (CSP 2011a) and QAA physiotherapy benchmarks (QAA 2001) revealed a high level of overlap between them, allowing them to be documented in one table (table one, Appendix o9). These criteria are emphasised as being the minimum standard for a qualified physiotherapist. All physiotherapists registered with the HCPC have to be prepared to demonstrate that they meet these

standards. By reviewing the criteria in tables one and two (appendix O) it can be seen that they consider ethics and behaviours (table two); interpersonal skills; knowledge, and practical application of physiotherapeutic techniques (table one). The HCPC and QAA criteria are based on generic healthcare professional (HCP) frameworks which are modified to each specific professional group. It is interesting that in all documents those more generic transferrable skills are at the forefront (standards one to twelve). One might question whether this indicates a higher regard for generic interpersonal and cognitive skills over specific therapeutic skills. The comparative importance of different groups of competencies has been debated within the health professions for a number of years with cognitive and interpersonal skills rated as being more important than technical skills (Elder and Nick 1997; Rangel *et al.* 2001; Cross 2001; VanMatre *et al.* 2004; Opie and Taylor 2008). This emphasis on clinical reasoning as more important than practical application of skills may facilitate the acceptance of students with impairments that limit their physical application of techniques.

When considering the standards from the perspective of disabled therapists, it can be seen that most of the criteria discussed in the ethics and performance document (table two) are reiterated in table one(appendix O), except for standard twelve which is discussed in the fitness to practice section later in this chapter. Closer observance of table one reveals that standards one to four may have an impact on people who have difficulty with developing relationships or organisational skills, such as people on the autistic spectrum, experiencing an acute mental health episode, or people with attention deficit (hyperactivity) disorder (AD/HD). However, people with these types of conditions often have developed coping strategies that can be adapted to clinical situations. Some standards do not have a negative impact on disabled students (standards five, six, seven, eleven, and thirteen). In fact, for standards five and six the shared experience of disability and discrimination puts disabled therapists at an advantage due to personal experience of the impact of equality, diversity and discrimination. Standards eight to ten concern communication either individually, in teams or as written records, which are essential skills for HCPs. These standards may impact on more students with various conditions, although in my

experience, the students who have the most difficulty are students with speech impairments. Certainly the participants in this study with note writing difficulties used alternative means of recording the information, whilst the students with hearing impairments were at an advantage when working with the older client group or in intensive care units where lip-reading is symbolic capital, increasing their value to the team in those situations. Finally, standards fourteen and fifteen concern the technical capabilities for physiotherapists. The wording of these standards includes many active verbs and phrases, such as ‘undertake’, ‘use’, ‘deliver’ and ‘be able to’, which could be seen to reinforce the concept of physiotherapists needing to be physically fit and active, thus creating an environmental barrier for students with physical impairments, who do not attune to the physiotherapy corporeal standard.

However, the HCPC stress that the method by which the standard is met is not questioned (Health and Care Professions Council 2013:3). This qualification allows flexibility for disabled practitioners to use reasonable adjustments or modify treatment and assessment techniques in order to meet the standards. When I inquired whether the HCPC representatives thought that the wording of some standards may be a barrier to therapists with physical impairments they replied:

“they should enable all practitioners to deliver competently, safely, effectively, but there’s a degree of flexibility as to actually how they might do that”

[HCPC representative #2].

“we’ve always said that there is a degree of latitude here... I’m a wheelchair user, I’m a qualified physio...I always have a physio assistant...she and I work together to deliver the intervention”.

[HCPC representative #2].

These quotes suggest the potential for flexibility towards the interpretation of the standards to enable disabled students to meet competency levels. This flexibility

is supported by the statement in the HCPC standards of proficiency document that recognises a practitioner's scope of practice may result in the practitioner not being able to meet all of the competencies (Health and Care Professions Council 2013:3). However, these representatives are interpreting these standards without possessing the *illusio* to the physiotherapy profession and the misrecognition of the physiotherapy *doxa* that a physiotherapist has within their *habitus*. Consequently, an attitudinal barrier to the integration of disabled students may be the literal interpretation of these standards by physiotherapists with a strong *illusio* to the physiotherapy *doxa*.

The *doxa* of the perfect physiotherapist is based on a general assumption of physical fitness and sportiness (Greenwood and Bithell 2005:75), which is demonstrated in the backgrounds of the majority of the students who participated in this study. Only one of them did not discuss their career choice for physiotherapy being associated with their enjoyment of sport or dance; some of them coming to this decision at sixth form college whilst others deciding after experiencing other degrees (sport science/therapy 3/10) or other physical occupations such as the army, police force, or personal trainer (3/10). It is not surprising that physiotherapy attracts active people; the prefix *physi-* meaning related to nature or physical (Merriam-Webster 2015). The strong association with sport is also due to sports people having treatment themselves after injury:

“as I spent quite a lot of time in physio I thought I might as well go and do it!”

[Jane]

or watching the physiotherapist run onto the televised football/ rugby field.

This high population of sporting people within the profession reinforces the physiotherapy corporeal standard; also resulting in a profession that is focused on the body, with a strong biomedical emphasis; *body-as-machine* (Nicholls and Gibson 2010:499). This interpretation is not isolated to opinions of patients, but also to fellow colleagues and themselves. In a study of physiotherapists with acquired musculoskeletal (MSK) disorders, Cromie, Roberson and Best (2002)

found that the physiotherapy corporeal standard causes physiotherapists who develop MSK injuries to be judged as negligent for getting the injury and then as 'shirking' for taking sick leave. The internalisation of these beliefs causes the injured physiotherapists to blame themselves as they "knew better" and hadn't done it "the correct way", suggesting that the physiotherapy doxa also implies immunity from MSK problems. As a result, the physiotherapists continued to work, even though their condition caused them great pain; one participant suggesting that they were probably in more pain than their patients. The authors claimed that this behaviour was due to the perception that taking time off is against the conviction of care and hard work that physiotherapists share. Hidden values like these are thought to be very deep and pervasive within a profession and new entrants are socialised into these beliefs through their professional education and their early career (Brooks and MacDonald 2001:134). These are also superimposed onto the doxa of disability resulting in attitudinal barriers against all disabled students.

I maintain that the doxa of the 'body-as-machine' model continues to be replicated within physiotherapy education, with the teaching of anatomy, physiology, pathology, and application of skills to the body overshadowing the teaching of cognitive and interpersonal skills. It is also reflected in student satisfaction responses, valuing modules teaching the former over the latter: even though interpersonal and cognitive skills are listed earlier in both the HCPC, CSP and QAA codifications, with the CSP citing values as being core skills rather than technical proficiency. It is therefore unsurprising that, with this body-as-machine philosophy still predominating, students with a physical impairment or condition are not seen as potential physiotherapists. Physiotherapists with a habitus developed within active and sporting structures have a great illusion to the doxa of physicality within the profession, which generates the negative attitudinal barriers already discussed.

Physiotherapy as a profession is a homogenous group. Within my previous research consensus on the attributes of physiotherapy students was

very strong (Opie and Taylor 2008). Öhman, Hägg and Dahlgren (1999:64) also reported a high similarity in responses in their research; suggesting that it was very difficult to find any disagreement within their participants. Although this research was conducted in Sweden, I could very strongly identify with the discussion given of the “competent professional women” reported by these authors. Bourdieu (1990a:195) warned that “institutions **create** the person they institute” [his emphasis]. This implies that the physiotherapy profession develops physiotherapists to fit the image of physiotherapy that it has created. Allen (2004:494) referred to this as professional corporeal attunement. This professional socialisation results in a homogenous group with a shared doxa, illusio and misrecognitions. The continued replication of the group is due to the dominant members selecting new members who fit with, or have the potential to fit, the group identity. Within the physiotherapy profession this replication is performed by admission tutors, who are all qualified physiotherapists, selecting the new generation of physiotherapists. Beattie and Johnson (2012) discussed unconscious bias in recruitment interviews, due to tacit attitudes causing recruiters to select people in their own image. I suggest this is exactly what Bourdieu meant with the above quote and I maintain that this occurs in the interview process for physiotherapy courses. Physiotherapy admission tutors would defend their selection criteria as being equitable and non-discriminatory, yet they are being applied by physiotherapists steeped in the doxa of the profession. Therefore the widening participation policies are being applied by professionals who have an illusio to the physiotherapy profession and misrecognise the ‘perfect physiotherapist’. Consequently, the profile of physiotherapy remains constant; in the case of disability, dominated by the physiotherapy corporeal standard.

8.3 The Paradox of Supporting Disabled Students versus Protecting the Profession

8.3.1 Supporting Disabled Students in Higher Education

The Equality Act 2010 (s91) requires higher education institutions (HEIs) and professions (s53) to support disabled students, offering them reasonable adjustments to the course and assessments to enable them to perform at their

optimal level (s20). It also includes a Public Sector Equality Duty (PSED) that requires all public organisations, to ensure prohibited conduct is eliminated, to enhance equal opportunities and to foster good relations (Equality Act 2010 s.149). This section of the Act might be seen as merely an administrative tool with public bodies responding by completing 'tick box' exercises such as impact assessments. However, (Carr 2014:210) discussed the importance of the PSED to ensure that decision makers take "due regard" of equality matters, especially at these times of austerity, where the government encourages independence in disabled people, yet cut their welfare support which would help to facilitate this independence. This view is supported by Crowther (2007:791) who suggested that the PSED marks a shift in attitude from "grudging acceptance" to promoting equality.

The current attitude by many people within HEIs for supporting disabled students is nearer to the grudging acceptance than promoting equality. Whilst the policies of HEFCE and QAA encourage increasing diversity and support for disabled students (Quality Assurance Agency for Higher Education 2010), the actual enactment of these policies is sometimes lacking. Harrison *et al.* (2009) reported on the provisions and support available to disabled students in universities throughout England and Wales. Although they acknowledged the many positive changes over the previous decade, and the many instances of good practices, they expressed concern about how embedded disability matters are within institutional business plans and the level of commitment from management and the general academic staff towards the integration of disabled students. The changes in the institutional policies provide a reduction in environmental barriers, which are implemented by central administration within the HEIs. However, I propose that whilst senior management within the institutions ensure the implementation of legal requirements there is a lack of commitment towards them, an absence of *illusio*, a view that is supported by Riddell and Weedon (2014:46). The management team set the tone for the institution as a whole, resulting in this ambiguous attitude penetrating down throughout the organisation leading to a generalised conception that supporting students with a disability is an extra irritant in an otherwise busy schedule. This viewpoint results in the bare minimum support being offered: standard disability

paragraphs in documentation and signposting to the ‘disability experts’ rather than support for disabled students being seen as integral to pedagogic delivery and academic pastoral care (see 9.4.2). I propose that a catalyst is required to facilitate a change in this attitude and the PSED may serve as this catalyst, especially in response to the current proposals to reduce the Disabled Student Allowance (DSA).

The Coalition government’s austerity measures have now focused on the DSA, spending on which has increased annually over the recent years (Department for Business, Innovations and Skills 2014: 5). In the equality analysis published by BIS (2014) they proposed to cut the amount of DSA available to students from 2016 onwards due to the wider common possession of technology, which has triggered a recalibration of the definition of ‘additional’ costs for disabled students. The report also highlights the potential overlap between DSA funding and the public duty for HEIs to make reasonable adjustments for disabled students (Department for Business, Innovations and Skills 2014:5). Consequently, the government has proposed a great reduction in the spending on DSA, requiring these costs to be met by the HEIs as part of their duty to provide reasonable adjustments. This change will be phased in over the next few years to allow the institutions to develop the additional policies and facilities required to support disabled students in the future. Whilst the government have acknowledged that there is a risk that HEIs may fail to meet their responsibilities, resulting in disabled students having no appropriate support, the report found no actual evidence that this will be the case (BIS 2014:7) and therefore, this is not sufficient reason to delay the course of action. I suggest that as the HEIs take up their responsibilities under the PSED this will begin to challenge the misrecognition that supporting students is an ‘additional need’ and the universalisation of read-write as the dominant learning style within education. The PSED will cause a definite change in environmental barriers and may also start to reduce attitudinal barriers too, which tend to exist at the level of the individual lecturer: “particularly in vocational fields” (Riddell and Weedon 2014:46).

8.3.2 Supporting Disabled Students in Physiotherapy Education

Physiotherapy education is one of these vocational fields, regulated by the HCPC and CSP: both having produced documents to support the recruitment and training of disabled students within physiotherapy education (Health and Care Professions Council 2006; Chartered Society of Physiotherapy 2004; Owen Hutchinson and Atkinson 2010; Health and Care Professions Council 2014a). These publications have evolved over the past decade and are affirmative towards the inclusion of disabled students. The HCPC's initial aim was to produce a document as guidance for the prospective student in response to uncertainty within the profession about the implementation of the DDA 1995:

“we used to get a steady stream of inquiries...from practice educators and admissions staff and also disabled people...that's why the guidance was produced originally...” [HCPC representative #1]

and written by a working party of professionals:

“Last time round it was developed by a working group” [HCPC representative #1]

“I was saying this shouldn't be led by us, it should be led by people with disabilities...” [HCPC representative #2].

The new version (Health and Care Professions Council 2014a) was written by the HCPC based on recommendations from qualitative research with disabled HCP students, clinical educators and academic staff on the process of integrating and supporting disabled HCPs (Clouder et al. 2013). Interestingly, the title for the new draft links health with disability: *“Health, Disability and Becoming a Health and Care Professional Draft Guidance”*. This is an example of misrecognition based on the negative doxa towards disabled people. Gabe (2013:49) asserted that many issues are medicalised in order to control deviance, which can be seen as symbolic violence by the dominant groups reinforcing the oppression of disabled people. Many people with a disability have good health and may not seek medical support any more than non-disabled people. Yet the

presence of the two words within the title of the draft document demonstrates the misrecognition that these concepts are inextricably connected within the negative doxa towards disabled people, which also affects the assessment of disabled students' fitness to practise (see 8.3.2.2).

The CSP's approach to supporting disabled students has been slightly different, initially focusing on clinical placements (Chartered Society of Physiotherapy 2004), which was expanded to the whole student journey from admission to graduation in the later version (Owen Hutchinson and Atkinson 2010), with one notable exception: there was no information for prospective disabled applicants or any student voice:

"that's not the format that we intended it to be... we're due to take that forward in the next six months or so... but.. the feedback on the content has been positive". [CSP representative #1]

Both organisations have published their documentation about supporting disabled students within physiotherapy on the websites of the respective bodies. However, when exploring the CSP and HCPC websites for these documents they were difficult to find; neither website had any information on the home page for disabled applicants, although the HCPC did have a tab for students whilst the CSP had a 'career' link. Unfortunately, neither of these links led to any information for prospective disabled students to help them with their career choice. Using the web search facility on the sites (accessed 08/03/13) and the search term 'disabled student' the CSP website generated 246 responses, with the top one being the appropriate document, which was fully accessible. The same search on the HCPC's website produced 100 responses with the 63rd item being 'Health and Disability' which linked to a page of the same title containing a link to the applicant guide. This low ranking may be because the document is in the process of currently being rewritten. Neither of the research assistants conducting the internet survey found information about the HCPC, but one of the students did link to the CSP website and managed to find their disability support document.

Representatives of both the HCPC and CSP agreed that these documents were not particularly accessible:

“No I agree... the search function on our website is not very good, one of the projects we’re looking at, at the moment, is ...overhauling the website.”
[HCPC representative #1]

“I’m starting to work more closely with our web team, because we want to better influence where they position [items]...things like ‘Into physiotherapy’ should be the first thing that you find when you’re looking for that”. [CSP representative #1].

Harrison *et al.* (2009:138) expressed the importance of accessible websites. They recommended that good practice would have links from the main home page to a specific area for information for disabled students. Whilst these findings were based on HEIs, they are appropriate good practice for the professional bodies as well. Again this displays the paradox between developing policies or documents and the actual implementation of these. Both organisations assumed that having the documents available on the website meant that students could access them, but none of the students in my study were aware of either document when they were applying for admission to physiotherapy, although some of them had searched for information on the internet. This highlights the existence of environmental barriers for prospective students considering a career in physiotherapy, when the positioning of information on a website is assumed to make it freely available to all.

8.3.2.1 Protecting Professional Standards

Whilst the Equality Act 2010 protects against discrimination, in the case of disabled students, it requires that professional bodies protect the confidence of the public by maintaining the standard of the qualifications that they award (Equality Act 2010 s96). Fitness to practise policies exist within many vocational professions and are used to assess “the skills, knowledge, character and health to practise safely and effectively” and are justified on the grounds of protecting the public from harm (Health and Care Professions Council 2012b:2). The

perpetuation of the need to assess good health and character in fitness to practise policies is supported by the Health and Social Work Professions Order (2001) in which Article 5.2 requires the HCPC to “prescribe the requirements to be met as to the evidence of good health and good character”, whilst Article 22 refers to allegations of misconduct due to ‘his [sic] fitness to practise is impaired by reason of ...his [sic] physical or mental health’. The conditions most cited as potentially causing risk are dyslexia, epilepsy and mental health; although there is no evidence to support these views (DRC 2007). In fact, (Marks 2007):73) asserted that there has been no research that documents any link between patient safety and the health status of an HCP.

8.3.2.2 Fitness to Practise in Physiotherapy

Within physiotherapy the regulation of the fitness to practise policy is conducted by the HCPC, although within physiotherapy education this responsibility is passed to the academic staff. As previously discussed the enforcement of these policies is dependent on the attitude of the individual and in this instance the interpretation of the meaning of the word ‘health’. The most commonly cited definition of health, within healthcare, is the one proposed by the World Health Organisation in 1946: “good health is the state of complete physical, social and mental wellbeing” (World Health Organisation 2015). In respect to the interaction between health and disability, the ICF was developed as “a universal classification system of disability and health” for use in healthcare organisations and useful as a policy tool. As previously mentioned, the ICF considers disability a “universal human experience” (World Health Organisation 2002:2-3). Thus using the ICF to interpret the World Health Organisation definition of health suggests that ‘complete wellbeing’ does not necessarily mean the absence of impairments. However, when disability and health are intrinsically linked in this way any assessment of health is also an assessment of disability. Whilst the ICF makes the concept of disability a mainstream experience the Equality Act 2010 also widens the experience of disability within its definition to not only include physical (and by implication sensory) and mental impairments (including neuro-diverse conditions), but also health deterioration, by the inclusion of long-term health conditions (LTC) such as rheumatoid arthritis, diabetes mellitus, cancer and multiple sclerosis (Office for Disability Issues 2012:

8). I would argue that although the declared intentions of the Equality Act 2010 and the ICF are affirmatory they both reinforce the medicalization of disability, by siting it on a continuum with health; maintaining the importance of the medical professions to provide diagnoses and acting as gatekeepers of society's resources: education, benefits, work, and fitness to practise within the vocational professions.

Unfortunately, fitness to practise policies remain entrenched in the historical classification of disability and health as deviant and the need to protect the public and the professions from people perceived as such (Carol 2002). As previously suggested, the medicalization of disability was used as a means to control deviance (Gabe 2013:49). Goffman's (1990) discussion of disability as stigma resonates with Bourdieu's theory of practice. The social structures, in this case vocational regulatory bodies, historically developed policies to protect the public from these "unclean persons" creating a negative doxa which has been replicated by misrecognition: regulatory bodies have a duty to protect the public from deviant people, and symbolic violence: people with disabilities and LTC are potentially dangerous and therefore must be excluded from the professions. This codification of discrimination is another environmental barrier that disabled HCPs face. In recent years high profile cases of health professionals who have murdered their patients have reinforced the call for strong regulation of the vocational professions (Stanley *et al.* 2011).

However, since the introduction of the DDA 1995 there has been concern about fitness to practise policies and their potential to be discriminatory (Sin and Fong 2007:46). In response to this question the Disability Rights Commission commissioned a formal investigation to review professional fitness to practise policies, particularly within the professions of teaching, nursing and social work (Disability Rights Commission 2007). Alongside this, a legal review had a more wide-spread remit including medicine, dentistry and the Health Professions Council (as it was at that time). The conclusion of the legal review warned that the more general the wording of a fitness standard then the more potential it had

to be interpreted in a way that led to discrimination, either directly or indirectly (Ruebain *et al.* 2006:8). They recommended framing fitness standards in relation to specific tasks and to focus on the person's ability to perform roles rather than to be a professional (Ruebain *et al.* 2006:94). The legal report closed by suggesting that there should be consideration of the need for health standards at all: the authors doubted whether these could ever be non-discriminatory. They advised that standards should solely focus on the registrant's ability to perform tasks competently and safely (Ruebain *et al.* 2006:95). Based on this legal report and all the other evidence collected within the formal review the overall recommendations from the DRC were:

“We recommend the revocation of the legislation, regulations and statutory guidance laying down requirements for good health or fitness of professionals. There are two reasons for this: the negative impact on disabled people; and our conclusion that they offer no protection whatsoever to the public...the DRC's investigation has found that these regulations do nothing to protect the public and may indeed offer a false sense of security.” (Disability Rights Commission 2007:3).

Nevertheless, these fitness to practise policies still exist, except for teaching in Scotland (Riddell and Weedon 2014:42), and still assess a registrant's health status. My analysis of fitness to practise policies with respect to physiotherapy indicates that the HCPC, as the regulatory body, is responsible for establishing fitness to practise. Until 2007 registrants were required to get a health declaration signed by their doctor (GP) confirming their fitness. However the HCPC reviewed their fitness to practise policies in the period 2005-7 in response to feedback from GPs:

“they used to complain...and refuse to sign people's forms” [HCPC representative #1].

These queries from GPs were based on a concern of having insufficient information about the job requirements to confirm or refute a registrant's fitness to practise. The drive for change initiated by these comments was bolstered by the disability Rights Commission report into fitness standards:

“...[DRC report] said the very fact that you have a health declaration dissuades some people...” [HCPC representative #1].

In response to this feedback the HCPC amended their fitness to practise policies to a self-declaration of health or disabilities that registrants consider may impair their fitness to practise. The HCPC (2012 c) published *“guidance on health and character”* to assist new registrants with the decision to declare a health or disability related issue. The guidance asserts that registrants only need to declare a health condition or disability if “your health may affect your ability to practise safely and effectively”. (Health and Care Professions Council 2012c:6). This demonstrates the entrenched doxa that physiotherapists with less than ‘good’ health or an impairment may be a potential hazard for colleagues and patients, reinforced by the misrecognition that an assessment of health is about protecting the public rather than the symbolic violence against diversity within the profession and universalisation of the concept of the view of a competent HCP.

The HCPC also include maintaining fitness to practise as a standard of conduct for initial and ongoing registration: standard 12 states that registrants must “limit your work or stop practising if your performance or judgement is affected by your health” (Health and Care Professions Council 2012a).

“we see that as quite an important standard which gets referred to a lot”
[HCPC representative #1]

However, when the HCPC conducted some investigations into the perceptions of these standards of conduct held by professionals and service users they were surprised to find that both groups felt that standard twelve was superfluous:

“both questioned why that standard’s there at all... and that it would be the employers responsibility to make sure those issues are covered”
[HCPC representative #1].

This change to self-regulation by the HCPC suggests that they are starting to move towards a more inclusive policy with the guidance offered reassuring people with health conditions or disabilities that if they have insight into their

condition; manage it appropriately; make adaptations to their practice; or limit their scope of practice, then they do not need to complete a self-declaration (Health and Care Professions Council 2012c:6). Nonetheless, this advice is somewhat vague and still some way from the DRC's recommendations to remove fitness to practise policies entirely, although this idea was not disregarded for future developments:

"I suppose... it's an...incremental approach, maybe in a few years we might think 'Do we need that declaration?'" [HCPC representative #1]

However, the misrecognition that health conditions impart risk was difficult to abandon:

"cos health is always something that can impair your fitness to practise" [HCPC representative #1].

The requirement for fitness to practise has implications for student HCPs, including physiotherapy students, because of the competing influences on course validation and curriculum design, from the multiple agencies involved within the field of physiotherapy education. I assert that this combination of education and health influences creates contradictory forces within the field of physiotherapy education. HEIs were included in the remit of disability legislation earlier than the regulatory and professional bodies and thus have been responsive to government legislation over a longer period allowing them more experience in responding to said legislation and also reviews by HEFCE, such as that conducted by Harrison *et al.* (2009). In contrast, the NHS is primarily about serving the needs of patients and its education role is secondary to that, which means that equality legislation supporting student HCPs has to be considered in relation to patient care (Hargreaves *et al.* 2014). This has resulted in disability services within HEIs disseminating good practice and the widening participation agenda encouraging early disclosure of disability by students. However, health professions courses have fitness to practise policies operating alongside this request for declaration of disability (Stanley *et al.* 2011).

Unfortunately, some students' applications are rejected during the admission process as the disclosure of their disability results in their current abilities being measured against the fitness to practice and competency levels of a new registrant. However, student physiotherapists have three years of education to enable them to achieve these standards and therefore it is unfair to use them to assess a disabled student's potential at entry (Carol 2002). Carey (2012:752) suggested that during the admission process tutors experience conflict between the inclusive curriculum espoused within HEIs and the functional education of a future HCP. He raised the issue that the funding body (LETB) penalises courses for high attrition rates, in the case of physiotherapy this punitive measure is double-edged, with the LETB having the power to cut commissions for future places at courses with high attrition. This constrains the actions of tutors, making them more risk-averse in recruitment and therefore less likely to 'take a chance' on a disabled student who may not meet the professional proficiency standards at the end of the course or who may withdraw before completion. This focus on attrition is a purely capitalist process of assessing throughput as a measure of the standard of courses, rather than using a means of assessing quality of provision. I maintain that whilst this remains it will continue to stifle even the most open of courses from admitting academically suitable disabled students whose impairments may be perceived as limiting, but who express a commitment and determination to challenge the boundaries of the profession.

I would argue that the assessment of a student's fitness to practise status whilst they are still training could be viewed as pre-employment screening as they are not required to register with the HCPC until the end of their training. The Equality Act 2010 (s60) makes it explicit that inquiries into the health or disability status of job applicants and pre-employment health screening are illegal, except in specific circumstances. Masupe and Parker (2013) surveyed occupational health physicians with respect to this section of the Act, finding that 63% of the respondents had changed their advice to employers about fitness for posts with 26% no longer giving unfit declarations when assessing employees. Although this applies to employment, it would seem to support the removing of fitness to

practise assessments conducted by professional regulatory bodies and courses, even self-declarations. The CSP document *“Into Physiotherapy”* supports this view by warning against prejudging the ability of disabled students within fitness to practice assessments at admission (Owen Hutchinson and Atkinson 2011:82).

Riddell and Weedon (2014:42) suggested that fitness to practise policies demonstrate a “contradictory imperative” for disabled students within health professions. On the one hand they are being encouraged to disclose their disability in order to access support and avail themselves of reasonable adjustments, whilst on the other hand this declaration may jeopardise their future career potential. This conflict seems to increase the dilemma for students when considering whether to disclose their disability status at university, but which seems to become more pronounced when declaring to the professional body:

“all the data is reliant on declaration and ...while they may declare to their university they don’t declare in the same numbers to the CSP” [CSP #1].

The difference of disclosure between university and the professional body may be simply based on perceived benefit: disclosure to the university results in accommodations and support whilst disclosure to the CSP is identified as information gathering and potentially career limiting. However, it might be a more complex strategy on behalf of the student to minimise the amount of information available to the professional body that they may recognise as being involved in the assessment of their fitness to practise.

I suggest that fitness to practise policies, and their implementation, remain an environmental and attitudinal barrier to the involvement of disabled people in the physiotherapy profession. In this instance the codification from the field of power is contradictory. The Equality Act 2010 aims to support disabled people to expect more opportunities and explore their potential by reducing structural barriers. In opposition to this are the fitness to practise policies for HCPs which require them to evidence their health due to the misrecognition that health and disability are inherently dangerous for the person with the impairment and those

with whom they come into contact. This environmental barrier is reinforced by the attitudinal barriers of the staff who implement these policies, within the HCPC based on misrecognition, but also at a local level within HEIs where the illusion to the physiotherapy doxa and physiotherapy corporeal standard is strong. This demonstrates that not all environmental or attitudinal barriers have been addressed within the physiotherapy field.

8.3.2.3 Physiotherapy Student Funding

Another environmental barrier for disabled students within physiotherapy education is student funding, which again is a potentially conflicting notion. The LETB that commissions the funding of places on course assesses the course at regular intervals to ensure the quality of provision. These organisations not only provide funding, but also placements for the clinical component of the courses. Most physiotherapy tutors have worked within the NHS for differing periods of time prior to becoming an academic physiotherapist. Therefore, their habitus includes a loyalty to the NHS as a national institution. This creates the moral obligation to ensure that all students funded are capable of working within the NHS once they are qualified so that the NHS is getting 'value for money'. If the students were self-funding (through the Student Loans Company) then the tutors may feel liberated from the moral obligation to the NHS and thus may take more chances at recruitment. Yet, one of the standards for physiotherapists is ethical behaviour and I suggest that many tutors would shift their moral duty from the NHS to the individual student. These dilemmas are faced by academic staff at the local level, with little guidance from central structures, and are reliant on positive attitudes towards disabled students (Carey 2012:752); physiotherapists who are willing to think the unthinkable (Bourdieu and Wacquant 1992:40) and break free from the misrecognition of the perfect physiotherapist.

Since the completion of data collection in June 2015, the Council of Deans of Health and Universities UK issued a joint statement requesting that the government reform the funding of HCP students, moving from the NHS to the standard student loan system that all other students receive. The reasons for this request are cited as being the restrictions of funding within the NHS to meet the

demand for future professionals. Due to the austerity measures implemented over the past five years the number of student places has been tightly controlled and the funding paid to the universities does not meet the cost of providing courses which demand high level of student: tutor ratios and expensive equipment. Furthermore, the council argues, the NHS bursary to students is not sufficient, with HCP students receiving less than fellow students receiving a student loan. Whilst this change is debated from numerous perspectives, from the perspective of the disabled student the move away from the current funding system will end the linking to the NHS and free the qualification courses to consider the students' future employability within a much wider scope of practice.

8.4 Student Experiences

The above documentary analysis and interview data from the representatives of the HCPC and CSP, has considered the policies of physiotherapy education from a theoretical perspective. The experiences of the student participants provide evidence of the actual practices occurring within the field.

8.4.1 The Paradox of the Perfect Physiotherapist: The Doxa within physiotherapy

Although the students did not comment on the Equality Act 2010 directly, Clare discussed her feeling that it was more socially acceptable to discriminate against someone on grounds of their disability rather than on race or gender, even though all of these are protected characteristics within the Act. This negativity and feeling of hidden discrimination against disabled people may be a contributing factor to students still not disclosing their disability on application to university. As Hannah states:

"I didn't want to [discuss her dyslexia at university open days] 'cos I didn't know whether it was going to influence their opinion of me..."

...It's like discrimination ... it doesn't happen, but it does!" [Hannah]

Clare and Hannah have identified the difficulty in using legislation to change attitudes, which are suggested as being the greatest barriers for disabled people to overcome (Carol 2002; Marks 2007:72).

These attitudinal barriers are based on the general doxa towards disability, which is so pervasive that the student participants have internalised it and demonstrate the misrecognition of disability being associated with impairment and inability:

“being physically disabled” [Lauren].

“stops you from being able to do or to take part in...” [Clare].

“the first thing I think of is a wheelchair” [Sally].

They also identified the label as being a negative categorisation:

“Di-[the prefix] which you know is negative” [Victoria].

“I think it’s quite offensive” [Sam].

Victoria discussed the use of this negative classification to create groups within society, and that the existence of groups underscores difference, creating the potential for prejudice and discrimination between groups:

“we [society] have to put them [disabled people] in a group...it’s the group over there: we know it’s here, but we don’t know what to do with it.”

[Victoria]

I maintain that the definition of disability used within the Equality Act 2010 acts as such a label, as an administrative tool. The Act purports to aim to reduce discrimination, yet it preserves the structural barriers by dividing society into competing groups; equally, it perpetuates the negative doxa that underpins prejudice and discrimination by its adherence to the individual/medical model of disability. However, it is difficult to offer an alternative means of identifying people who need support:

“unfortunately, we do need labels, otherwise we would not be able to identify those who need more support or guidance...but the aim is to create equal opportunities” [Alison].

The internalisation of the negative doxa towards disability may be the basis of the reluctance to disclose as discussed in the previous chapter. One consequence of top down policy, such as legislation, is that the behaviours legislated against become hidden. People know what they are not allowed to do, so perform these behaviours covertly. Alternatively, Deal (2007) used the term aversive disablist to describe people who condemn discrimination, yet do not perceive their own prejudice and discriminatory practices. I have heard, and have had comments repeated to me anecdotally such as, ‘I know we’re not allowed to reject them because of their disability - so we’ll have to find a different reason!’ This is an example of hidden discrimination and symbolic violence, creating an attitudinal barrier for disabled students. It might be expected that health professionals had a better attitude towards disabled people than the general doxa. Unfortunately, this is not necessarily the case. This phenomenon has been investigated by a number of authors over the past years identifying the general trend that student health professionals’ attitudes are more affirmative as they progress through their course, but become more negative again once they enter post-registration practice (Chubon 1982; Paris 1993). A comparative study between occupational therapy and physiotherapy students indicated that physiotherapists had the most negative attitudes towards disabled people, which was similar to that of the general public (Stachura and Garven 2003). Morris (2002) suggested that this negative attitude might be associated with the professionalization of physiotherapy. I contend that changing these attitudes will be key to widening the integration of disabled students into the physiotherapy profession (see 9.2).

The attitudinal barriers are entrenched within the physiotherapy doxa and corporeal standard. As discussed in section 8.2, standard 14 (table one Appendix O) includes the physiotherapeutic technical skills and this is the standard which has the greatest impact for students with physical disabilities. Hannah, Sally and

Jackie declared a physical disability within this study and these were the only students who were assessed by an occupational health service. This would suggest that physiotherapists and the administrators within the HEIs consider physical ability to be paramount and were not so concerned with cognitive abilities which may impact on students with dyslexia, AD/HD and mental health issues; or interpersonal skills which may impact on students with visual, speech and hearing impairments.

The overriding importance of physical ability is encapsulated in the experiences of Jackie who was hospitalised for a number of months and it was agreed that she would temporarily withdraw until the following year, when she would recommence year two. As her treatment progressed it became apparent that she would not fully recover resulting in her becoming a wheelchair user and being permanently withdrawn from her course, against her wishes. When Jackie sought support to continue her physiotherapy studies she was met with resistance. The course claimed that she would be a health and safety risk and the CSP were “*wishy-washy*” about the legality of this situation. Independent advice left Jackie feeling reluctant to exert the necessary effort to pursue legal redress:

“I thought... I’ve got to step back and think whether or not this is a good way to be spending my time and energy... you’ve got to pick your battles”.[Jackie]

The Equality Act 2010 is a rights-based piece of legislation, requiring the person to recognise and prove that they have been discriminated against: the victim must prove the culprit’s guilt (Woodhams and Corby 2003:161). Lawson (2011:362) suggested that in many instances discrimination cases have focused more on the limitations of the disabled person rather than the activities of the alleged discriminator. The individual responsibility to seek compensation may be seen as symbolic violence as the claimants are denied resources to help them to establish the discrimination, especially as disabled people are identified as being one of the most socially and economically disadvantaged groups within British society (Crowther 2007). To enforce this legislation much importance is put on the definition of disability resulting in the disabled person’s impairments and

related inabilities being publicly examined and this has been said to be analogous to cross examining a rape victim (Lawson 2011:361). In Jackie's case she was made to feel guilty for considering legal action:

"I felt like I was gonna be bringing the name of the physio and university down"
[Jackie]

This is both an example of symbolic violence, attitudinal barriers and aversive disablism. Jackie was willing to try to continue her education, and possibly fail, but her new embodiment was so dissonant from the physiotherapy corporeal standard that this was not considered possible by anyone from whom she sought advice. It might be argued that physiotherapy is not a suitable profession for a wheelchair user. That it lies beyond the bounds of what is 'reasonable' when considering adjustments. However, earlier this year I was approached by a colleague at a conference for advice on supporting a physiotherapy student who is a wheelchair user. This student was fortunate to apply to a course that had tutors willing to think the unthinkable (Bourdieu and Wacquant 1992:40).

In a similar manner Jane had issues on placement due to her dyspraxia affecting her manual dexterity, co-ordination and balance:

"on a couple of occasions I did get marked down on it...because they just didn't think that I was doing...the correct technique" [Jane]

Although her adjustments to techniques were reasonable and also effective for patient care, they didn't look neat and fell outside of the corporeal standard resulting in her lower marks. In my role as a learning support tutor, I have also had practice educators concerned about students with rheumatoid arthritis wearing splints within the hospital environment or just coping with the day-to-day practicalities of being a physiotherapist. On one occasion a very good student with rheumatoid arthritis came back from a four week placement, at the end of her second year, where the physiotherapists had spent the whole time telling her which areas of physiotherapy she would not be able to work in. These experiences demonstrate that not only do the competencies constitute

environmental barriers for some disabled students; the way they are interpreted and applied is often more constraining because of the attitudinal barriers that exist within the field.

The previous discussion of the physiotherapy doxa and corporeal standard might imply that students with impairments that are hidden (dyslexia, AD/HD, mental health or sensory impairments) do not experience any attitudinal barriers; but this is not the case. Although most participants who discussed their impairments during the admission process did not encounter any negative responses, some students commented on the difference between the responses of physiotherapists working within the HEI compared to clinicians. They felt that the opinions within clinical placements were less positive than those within the HEI.

“on placement it’s quite different. Sometimes it wasn’t mentioned [a pre-clinical letter disclosing xx’s mental health issues] on one occasion [they said] ‘you don’t look any different to anybody’” [Victoria].

“I think attitudes were hard on placement...they [said] ‘you weren’t what we were expecting!’” [Hannah]

I suggest that these differences are another example of the division between HE and the professions. The academic staff have to respond to policies from HE, NHS, HCPC and CSP, whereas clinicians only have to consider the NHS, HCPC and CSP. If, as previously mentioned, the widening participation agenda within HE encourages diversity within the student body; the clinicians’ experience of impairment on a daily basis is to assess the deviance from the normal and work to ameliorate this. Consequently, clinicians’ underlying principle is the identifying of problems in people with impairment, creating a negative attitude towards disability focusing on inability rather than ability. This is buttressed by the general doxa towards disability that assumes risk and reduced ability to contribute. Hargreaves *et al.* (2014:310-311) argued that the difference in support between HEIs and the NHS is due to a difference in culture. HEIs’ primary function is the education and support of students whilst the primary function of the NHS is the health and safety of the patient, with educating HCPs

as a secondary function. Consequently, the disabled students' needs will always be considered secondary to the wellbeing of the patient. Unfortunately the negative doxa towards disability often results in the needs of patients and disabled students being considered as in opposition, when often this is not the case, as discussed previously when considering empathy.

On reflection, when I was a novice academic tutor and new to the role of learning support, a student with a cochlear implant, who primarily used signing and lip reading as her main forms of communication, was recruited into the first year of our physiotherapy course. My clinical background was in paediatrics, where I spent a lot of time behind the children talking to them without visual contact. From my hearing perspective, I could not imagine how this student would cope in specialities that limited her ability to lip read. However, from working with her throughout the first eighteen months of the course I began to realise that she would cope. This student had shown me that there were alternate ways to achieving communication and that in some specialities her skills of lip reading made it easier for her to understand patients. I had misrecognised the doxa surrounding the communication between practitioners and patients: it was unthinkable to me that a person who relied on lip reading could function within a health care setting. This experience, at the start of my academic career helped me to become more reflexive in my practice: to "examine my unthought categories of thoughts" and "delimit the thinkable" (Bourdieu and Wacquant 1992:40).

I have also experienced these deep seated attitudinal barriers when discussing, with academic colleagues, the positive findings about disabled physiotherapists having increased patient empathy and having to be determined and extremely hardworking to succeed (see 7.8.2 and 7.8.4). One colleague responded that they thought themselves very empathic to service users, whilst the other asserted that all physiotherapy students and physiotherapists were hardworking. This demonstrates aversive disablism (Deal 2007) by two people who would describe their practice as non-discriminatory. However, they do not perceive their own illuso to the doxa of physiotherapy, which superimposed on

the doxa of disability causes attitudinal barriers for all disabled physiotherapy students to negotiate. Jackie summed up the illusion of physiotherapists towards these combined doxa when asked if things could have been handled differently:

“just to actually open up their minds...and discuss their worries... their perceptions...we could have sat down and talked through it all” [Jackie]

Thus it is attitudinal barriers that need to be addressed to facilitate change and further inclusion of disabled students within the profession. (Marks 2007) suggested that attitudinal change is best produced at a local level:

“I feel integrating students with disability and non-disabled can learn a whole lot...this involves teachers as well as other students”. [Alison]

Pred (1990:24) referred to this process as localisation; change instigated by agents as a local level (see 9.2).

8.4.2 The Paradox of Supporting Disabled Students versus Protecting the Profession

Of the ten students involved in this project, Hannah and Sally were required to have an occupational health assessment as part of the admissions process, due to their physical impairments. They found the occupational health assessment process distressing as they were very conscious that their potential physiotherapy career was in jeopardy:

“I hated it [health assessment]. It felt like they were assessing if I was good enough to be here” [Hannah]

“...it was upsetting, I was crying when I came out...the way she just sat there and picked on things...wasn't very nice”. [Sally]

Both students felt that they were being judged unfairly, with Sally being told that in the past she would not have been offered a place due to her rheumatoid arthritis. Although she was accepted on the course, showing a widening of the physiotherapy corporeal standard, the comments from the physiotherapist who assessed her suggest a level of reluctance and aversive disablism (Deal 2007).

The implementation of fitness to practice policies also affects student placements. For example, Jane had great difficulty memorising normal blood gas levels and consequently failed her respiratory placement:

“I just had an absolute panic and I’ve had a mental block about them ever since!” [Jane]

Whilst discussing her career plans she affirmed her reluctance to work in that area:

“I don’t want to go into respiratory – anything but that!” [Jane]

She herself has recognised the limitations that her dyscalculia and dyslexia have in areas of physiotherapy that are number orientated and has made a conscious decision to limit her practice in response to this, which is the action supported by the HCPC standards of proficiency (Health and Care Professions Council 2013: 3). Nevertheless, there is a concern that students experience placements in the three core areas of physiotherapy (cardio-respiratory, neurology and musculo-skeletal), a stance argued on the grounds of giving a student a wide foundational base for their career and to ensure competency standards across all areas of the profession. This creates another environmental barrier, especially when a student fails a particular placement like Jane. She was fortunate to pass her repeat placement, but another student may have been less successful resulting in them being withdrawn from their course.

8.5 Summary

This chapter has considered the field of physiotherapy from both a theoretical and practical perspective. The documentary analysis reveals a potential for flexibility for disabled practitioners. Ironically, this flexibility allows for interpretation of these policies at an individual level. This personal interpretation is influenced by the habitus possessed by the individual, which in the case of a physiotherapist includes an *illusio* to the physiotherapy *doxa* and corporeal standard. These deep seated beliefs produce the paradox of the perfect physiotherapist that most therapists fall short of in some way, but disabled

students are expected to attain, resulting in attitudinal barriers against their integration into the profession.

Unfortunately, these attitudinal barriers are reinforced by the environmental barrier of the fitness to practise policy. The HCPC's requirement for courses to consider the future fitness to practise ability of students has the potential to be discriminatory against disabled students, particularly those with a physical impairment. The fact that no student has challenged this practice is probably due to the limitations of the Equality Act 2010 and the structural barrier of the general negative doxa towards disability. If more disabled students are to be able to access physiotherapy as a profession change will be required at structural, environmental and attitudinal levels, which is discussed in the following chapter.

Chapter Nine: A Brave New World: Overall Discussion

“Any definition which separates people into disabled and able bodied is on one level extremely unsatisfactory, because it perpetuates what one might refer to as the ‘myth of the healthy body’” (Sutherland 1981:17)

9.1 Introduction

This research started out as being a qualitative investigation of the integration of disabled students into physiotherapy. It has grown into a sociological discussion of the contradictions that face disabled students within England today, particularly within the HE system and healthcare professions. Moreover, some of the findings may be generalised to the wider educational system and even society at large. The main paradox is how to change grudging compliance to positive equality, when the bottom line always seems to be cost within the liberal equality philosophy currently adopted by Western governments (Liasidou 2013:308; Parker-Harris, Owen and Gould 2012:824). Laws, such as the Equality Act 2010 which predominately address environmental barriers, seem to have little effect on structural or attitudinal barriers. As Sutherland (1981:17) identified above, whilst we continue to divide society into groups we will continue to perpetuate identifying difference and consequential prejudice rather than embracing diversity. We need a new model of ‘disability’ and ‘normality’ which is fully inclusive; offering support to all without relying on the applications of labels by healthcare professionals as sanctioned by the government.

Building on the findings chapters this overall discussion chapter serves as an attempt to outline possible ways of initiating change, starting from the participants’ suggestions (Appendix Q) and then widening to a more general discussion of the potential for change. I use both Swain, French and Cameron’s (2003:2) SEAwall model of discrimination and Bourdieu’s Theory of Practice (1977) to demonstrate the changes needed to create an inclusive physiotherapy education system. The interaction between these theories is demonstrated in figure 9.1, the size of the arrows being proportionate to the influence that I

consider each component exerts. Thus attitudinal barriers reside within a person's habitus, which contributes to and is developed from the general societal doxa residing at a structural level. The field introduces environmental considerations which both effect and are affected by the habitus and doxa. Thus the system reproduces itself and its inherent stereotypes, prejudices and discrimination in a cyclical manner rather than a linear fashion as suggested by the SEAWall.

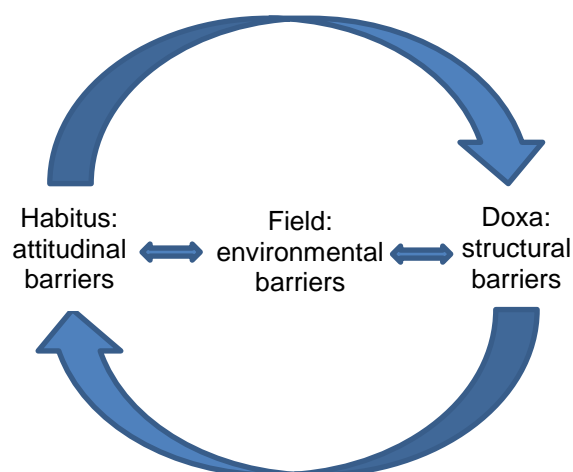


Figure 9.1: Relationship between Swain, French and Cameron's SEAWall of discrimination and Bourdieu's Theory of Practice

It must be noted here that Bourdieu himself disliked circular models to represent the iterative nature of habitus and structure as they misrecognise the relationship: habitus is embodied structure and therefore the two exist within each other (Bourdieu and Wacquant 1992:135), but this is very difficult to illustrate on paper, so I will persevere with a circular depiction.

Each group of barriers encountered by disabled students within physiotherapy education are discussed, incorporating their recommendations in order to establish a blueprint for a new construction of dis/ability within this field. However, rather than starting with society and structural barriers, I commence with attitudinal barriers at the individual level. Pred (1990:124) discussed the processes by which agents can transform structure using the concept of regionalisation, which I apply to disabled physiotherapy students and their effect

on the habitus of physiotherapists with whom they work. I then progress onto environmental barriers, including a discussion of how to address change for disabled people within the physiotherapy profession via distancing (Pred 1990:124). Finally, I consider the big picture: enacting change at a structural level. Here I combine Gable's (2014) development of Critical Realist Disability theory with Bourdieu's Theory of Practice to introduce a framework for understanding the sociology of disability and the idea of a potential future inclusive profession, and possible inclusive society.

Whilst this discussion will itself be linear I have already acknowledged that I consider the process of social interactions to be complex and interrelated (see figure 9.1). Thus change needs to be introduced simultaneously in each position. The implications of this change within the field of physiotherapy are discussed, and divided into the individual, environmental and structural levels. Due to the ongoing self-perpetuation of the system I suggest an alternative theory for understanding the social construction of disability in the form of a disability Ouroboros: a mythical snake that eats its own tail which was used as a symbol for eternity or infinity. I use this new model that I have developed to demonstrate and critique the negative aspects of the current system which establishes in perpetuity the opposition between disability and ability. This constant iteration of the construct of disability needs to change from focusing on a difference that divides, to similarities that unite us all in a shared experience of humanity or human being (Dreyfus and Rabinow 1993:36). Thus, in order to enact change the iteration between habitus and structure needs to be amended to an inclusive response to all potential physiotherapy students.

9.2 Attitudinal Barriers: Change at the Individual Level

"The more time people spend with me I think the more they learn how to adapt to it [hearing impairment]" [Clare]

This comment by Clare demonstrated her awareness of the capital that she possesses to introduce change in the attitudes of the therapists that she meets. The habitus of these physiotherapists incorporated this new information

about hearing impairment potentially making them more positive towards future students or colleagues with a similar impairment. Therefore, I suggest that the experience of supporting disabled students produces an evolution of the habitus of the clinical educators, which then affects a change in the local social structure; both spatially and temporally. Those clinicians, at that location (geographically), who worked with Clare, now possess a more positive attitude towards people with hearing impairments which will also facilitate the future inclusion of students with a hearing impairment (temporally). Thus, from an individual level, transformation is initiated by a modification in the attitudes of the individuals who implement policies, i.e. the physiotherapy tutors who admit, advise, and support students during their training. Disabled students and qualified professionals are not passive in this process; they possess the potential to have an impact on the social structure of physiotherapy and the habitus of other physiotherapists within their own placement or working locations. These are referred to as Locales which represent social relations occurring within a geographical context: “physically bounded” (Pred 1990:123). Cohen (1990:44) suggested that these face-to-face interactions have stronger effects on conduct and relations than rules in the wider system. A suggestion supported by Gable (2014:88) with respect to the attitudes of practitioners towards disabled students. Within healthcare Kontash *et al.* (2007: 299) found an increased willingness from nurses who had worked with a disabled colleague to work with nurses with the same impairment and French (1987) claimed that increased familiarity of impairments would widen the participation for disabled students within physiotherapy.

Thus, if more disabled students are successful with their physiotherapy application the physiotherapy tutors’ experiences of supporting disabled students will increase, challenging the misrecognition of the physiotherapy doxa and expanding the physiotherapy corporeal standard. The attitudes of the nurses involved in the study by Kontash *et al.* (2007:300) were also more positive towards working with all types of impairment. Consequently, I assert that the presence of disabled students not only challenges the physiotherapy corporeal standard associated with the particular impairment, but will also help to challenge all stereotypical categorising of disabled physiotherapy students. In the wider HE

field, Georgeson (2009:162) discussed that the way disabled students negotiate their learning support is not an individual process; often being the catalyst for change within the wider institution. Thus disabled students are role models within their locale. They can positively affect attitudes towards future disabled students: or produce negative effects if they have problems. I would postulate that a positive effect might need more than one successful student to achieve positive change to habitus and doxa as the first student may be disregarded as the 'exception that proves the rule'. However, it will only take one unsuccessful student to reinforce the negative attitudes towards students with similar impairments: 'we knew it wouldn't work!' I will explain this by comparing and contrasting Social identity theory with a social interaction theory of disability proposed by Winance (2007).

Social identity theory considers the social beliefs of individuals being strongly influenced by the social beliefs of the group to which they belong (Hayes 2002:89-90). In the above situation the clinical educator's beliefs are based on those of the social group relevant to the situation: the physiotherapy doxa. This schema categorises disabled people as patients, dependent and needing help. The idea of a disabled person being a colleague is dissonant to this doxa and would be ignored or dismissed, but the situation of having a disabled student on a clinical placement does not allow this. This creates unease in the educator and they look for characteristics in the individual to support the categorisation of the doxa (Hayes 2002:91). If the disabled student continues to display characteristics that do not conform to the doxa then the clinician adapts their habitus to suggest that some disabled people are independent, resourceful and capable of being a physiotherapist, i.e. the exception to prove the rule (Hayes 2002:87). This adaptation would create a subgroup for disabled people who might be suitable physiotherapists. However, the overall stereotype is only changed if the clinician is exposed to non-conforming people on multiple occasions (Whitley and Kite 2006:107). Conversely, if the student performs behaviours that support the assumptions and stereotypes then this is assimilated into the clinician's habitus reinforcing the doxa through the process of a self-fulfilling prophesy: 'we knew it wouldn't work!' (Whitley and Kite 2006:152).

An alternate theory could be based on rupture within the individual social interaction. Winance (2007:269) described this rupture occurring when disability affects social interactions between people. On initial meetings the interaction occurs “as if” each participant is ‘normal’. If one of the people has an impairment, which affects the interaction, dissonance is created, resulting in a ruptured interaction. However, if the person’s impairment does not have an impact (hidden or accepted impairments) on the social situation, no rupture exists and the interaction proceeds in a fluid manner (Winance 2007:631). Ruptured interactions require the clinician, as the person holding the most power in the situation, to amend their habitus to incorporate the difference exhibited by the student into the physiotherapy corporeal standard. If this occurs, future interactions will proceed fluidly and the student will become accepted with their impairment minimised or disregarded. Conversely, if this “work on the norm” (Winance 2007: 634) does not occur the student’s impairment often becomes the focus of the interactions requiring them to attempt to attune to the corporeal standard or to hide their impairment entirely. Whilst both SID and Winance’s theories can have positive or negative consequences for the disabled student, Winance (2007:629) argued that the former leads to “political dead ends” (p.629); the corporeal standard remains untouched requiring all disabled physiotherapists to attune or mask their impairments whilst the latter produces “political openings” (p.633) with the corporeal standard being modified to incorporate a wider definition of ‘normalcy’. From a Bourdieusian perspective both theories fit with the concept that habitus is not fixed or passive, but an active process that is open to change (Hage 2013a). The high level of homogeneity within physiotherapy (Öhman, Hägg and Dahlgren 1999:64) indicates a strong group cohesion leading to a strong group identity. This supports the SID analysis of the situation. However, within that theory there is balance between group and personal identity. Some people within the group may subsume the group identity to their personal ideology (Whitley and Kite 2006: 313) and I suggest that these people will be more accepting of disabled students as they are able to “work on the norm” and adapt the physiotherapy corporeal standard in this situation (see 9.3).

From the students' individual perspectives, there was agreement that disabled students need to start planning for their transition to HE promptly, which supports the previous discussion about the preparation needed by disabled students when starting at university (see 7.9.2). They recommended that future students need to be proactive and determined and should be encouraged to make contact with the respective courses early to establish a rapport. This early contact will allow students to discuss their impairment and support needs in an open exchange with the admissions tutor of the specific course, but also to make a personal connection. The discussion would best be initiated at an open day event allowing the students to make the geographical and temporal connections that Cohen (1990:44) and Pred (1990:123) maintained are more powerful in delivering structural change. The personal connection will allow the disabled applicants to use the capital that they possess to demonstrate strategies for success. One of these strategies might be corporeal attunement (a normalisation orientation) which seems to be the strategy of choice of students with hidden impairments, or to challenge the physiotherapy corporeal standard, which may be chosen consciously (an affirmative perspective), or reluctantly in the case of some students with a visible impairment. However students challenging the physiotherapy doxa need to be very determined and eloquent in arguing their case and demonstrating their potential ability to succeed. Even then, these students may be compared to the physiotherapy corporeal standard and found wanting, due to the misrecognition and *illusio* based on the physiotherapy admissions tutors' habitus. This need to negotiate identity during the application process is not unique to physiotherapy education (Riddell and Weedon 2014). Nevertheless, I contend that expecting disabled prospective students to adopt an affirmative role, against their natural habitus, would be placing them in a quandary: challenging the existing doxa whilst attempting to assimilate into a new field. Many students would find this difficult at this stressful time of transition, possibly discouraging some from continuing their application.

The changes at the individual level already suggested depend on disabled students being determined, proactive and also possessing an affirmative or situational identification (Darling 2003). As previously identified, many students

adopt a normalisation approach, which would not produce the transformations described above. I maintain that this approach actually reinforces the negative attitudes within the physiotherapy doxa and could explain why any change occurs so slowly. Darling (2003) suggested that most disabled people adopt a normalisation approach, possibly due to internal oppression. Resultantly, disabled people with an affirmative approach become an even smaller minority who can be disregarded either by labelling them as heroic or as trouble-makers (Northway 1997:738-9). Bourdieu (1993:73-4) asserted that the most likely people to challenge the doxa of the field are the new entrants, as the socialisation into the field develops the *illusio* to maintain the status quo. However, I disagree; physiotherapy degree programmes have high entrance requirements and all students undergo intense competition to gain entry into the profession. As a result the new entrants have already developed the *illusio* to the profession and are eager to gain position by impressing tutors with this *illusio*. In contrast, existing disabled students, who are comfortable in their position within the field, might be a more viable alternative to create locales and to challenge the physiotherapy corporeal standard. They can also act as role models for new entrants:

“If I’d had the opportunity to speak to other students that had been there... I think that would be really good to have at open days” [Hannah].

Thus existing disabled students would affect the physiotherapy doxa and the attitudes of both physiotherapists and applicants by portraying an affirmative orientation to disability and demonstrating their capabilities and the potential of physiotherapy as a career for disabled people.

Whilst many of the students acknowledged that their provision had been useful and supportive, they also identified that an improved awareness of disability, both within the university and clinical environments, would further enhance the support of students’ learning needs:

“she said that if I’d applied for a physio course in her day I wouldn’t have got on one...I don’t think there was any point in her saying that to me.” [Sally]

“I’ve even had lecturers making comments about you know, ‘being sent to the funny farm, and... the majority of students that are very developmental age, you know learning from their peers, what’s acceptable behaviour and we all go ‘oh, you can say that, that’s fine’”. [Victoria]

These comments made by tutors are examples of aversive disablism (Deal 2007) and they identify the underlying misrecognition of the physiotherapy doxa and the symbolic violence towards people with mental health issues. Jackie’s experiences exemplify the combination of misrecognition and symbolic violence towards disabled students, particularly those who are wheelchair users. Insightfully, she identified this as *“closed minds”*. I maintain that these attitudinal barriers are entrenched in the individual’s habitus which is the embodiment of the social structures inhabited by the therapists. Therefore, these barriers, reside at both an attitudinal and structural level.

This reinforcement between habitus and structure identifies why legislation at an environmental level does little to change society. As long as the structure or habitus are not amended they will continue to reproduce each other. Changes at the environmental level, in the form of legal requirements, policies and procedures, serve to inform the individual what is formally expected within the field; the codification of standards (Bourdieu 1990a:80). However, if the structure remains unaltered the habitus will remain unaffected. Thus people respond to legislation at an administrative, politically correct level, rather than demonstrating any illuso to the concept of an inclusive educational environment: their minds remain closed. These closed minds can be observed in aversive disablist comments like those above, but also in educational attitudes in general, where teachers purport to embrace inclusion, yet demonstrate practices which maintain segregation of disabled children (Hodkinson 2012: 679). This is also why attitudinal research is very difficult, as people’s responses are socially biased and demonstrate a complex linkage between professed attitude, stereotypes, social acceptance of desired behaviour and actual behaviour (Whitley and Kite 2006:403). Esses and Miao (2002:72) claimed that attitudes have both emotive and cognitive components; with respect to disabled people these are comprised

of one emotive and three cognitive elements: emotions elicited by the disabled person; stereotypes attributed to disabled people; symbolic beliefs about disabled people that may promote or threaten the observer's values, and finally an estimate of the control that the person has over their impairment (Deal 2003:900). Previous research into the attitudes of HCPs towards disabled people suggests that physiotherapists conform to the general doxa of disability demonstrating negative attitudes (Morris 2002; Stachura and Garven 2003). Cromie, Robinson and Best (2002), O'Hare and Thomson (1991), and French's (1987) research into the attitudes of physiotherapists towards colleagues with impairments might actually suggest that in these instances our attitudes are more negative. I propose that this is because we, as a profession, focus on the body as both our working environment (patients) (Nicholls and Gibson 2010) and our tools (therapists) (O'Hearn 2002) thus reinforcing the illusion to a narrower physiotherapy corporeal standard, which has a higher standard for physical capability, and the misrecognition that disabled therapists could not find alternative methods to assess or treat patients. However, within all groups of people there will be individuals who have more open minds: who think outside of the box or think the unthinkable (Bourdieu and Wacquant 1992:40). Pearson *et al.* (2011:265) suggested that frontline staff are crucial in the implementation of policies, claiming that they can "reshape or pervert policy intentions...or be more creative". My findings suggest that change will occur when a determined student meets a creative tutor and they collaborate to challenge the boundaries of the profession (Bourdieu and Wacquant 1992:81). In such cases it is essential that the changes occurring at the locale are communicated both spatially and temporally within the field of physiotherapy education.

9.3 Environmental Barriers: Change at the Organisational Level

The participants made many recommendations for change within the field (Appendix Q), most of which are applicable to all areas of HE, whilst some are specific to healthcare courses and physiotherapy in particular. From the overall system the students wanted to see information more readily accessible for prospective applicants during their decision making processes. The difficulties in accessing useful information have previously been discussed (section 7.9.1). The

contributors requested that information for disabled students should be more obviously highlighted on the front page of university websites with a more logical process linking the generic information to faculty and subject specific information. The posting of universal, vague, non-discriminatory, standard paragraphs was seen as insufficient and unhelpful. The students demanded more: affirmative information linked to individual courses.

*“It would help if it was in a positive way...and also if it’s more prominent there”
[Victoria]*

One specific improvement suggested for websites is the inclusion of podcasts to document successful disabled student journeys, whilst another was the development of a disabled students’ information pack provided by courses:

“a pack of information...in advance, whether it’s on the web or hand-out” [Helen]

Increasing the amount of available material would help the students in making an informed choice about the university and course that is suitable for them; a process which the participants have identified as being difficult and time consuming at present. This level of information would allow them to gather the facts pertinent to them in a protected private manner. If the websites included the affirmatory material, podcasts and advice on managing the transition to university suggested by the participants in my study then it should help the students feel more at ease with discussing their impairments and support needs during the admission process; reducing their anxieties about discriminatory practice or negative attitudes (section 7.2). Students who do not disclose, due to a lack of identification with the label of disability, also need to be encouraged to discuss their needs at various points throughout the admissions and enrolment procedure; the availability of this information would also facilitate this process. I propose that the discrepancy between the information made available on university websites and that required by the students is due to the administrative response to the Equality Act 2010 adopted by many institutions (Riddell and Weedon 2014:46), which results in this provision of minimal information and basic legal compliance. Although the Act has introduced change and addressed environmental barriers, because it is implemented by individuals who do not have a commitment to the claimed underlying purpose of the Act, i.e. disability

emancipation, they respond grudgingly offering the bare minimum, be that information on the website or other implementation of the legislation. This behaviour is often associated with a feeling of insecurity about the processes involved. Therefore increasing disability awareness training for frontline staff should help to reduce this vulnerability and increase the personal awareness of disability and the various provisions for both the disabled students and the educators who support them (Arshad and Riddell 2011: 235; Harrison *et al.* 2009:146).

Another environmental barrier that affects healthcare students is the implementation of fitness to practise policies and professional competency standards, particularly during the admission process. Whilst the protection of the health and safety of patients within the healthcare field should be paramount, it should not be used to justify not offering reasonable adjustments (Kane and Gooding 2009:21). Furthermore, many authors (Riddell and Weedon 2014; Sin 2009; Stanley *et al.* 2011; Wray 2005) suggested that fitness to practise policies are no longer necessary. Insight developed during this research suggests that the continued application of these policies, based on being of good health and character, at best limits the ability of these professions to reflect the communities which they serve (Department of Health 2000) by restricting access to disabled people. At worst, they act to protect the professions' misrecognition of the ideal HCP, constraining the evolution and development of the health professions. As previously discussed, the application of these fitness to practise policies at the admission to courses is against the spirit of the Equality Act (2010 s60), which has identified pre-employment screening as discriminatory, and widening participation policies of HEIs. The disabled applicant's ability should not be judged at entrance to professional education, but on registration to the profession itself, after the student has been given the opportunity to establish their abilities against the competencies of the profession, in the same way as for non-disabled students. However, currently these policies are being applied at admission using occupational health assessments, not in a capacity of protecting the health and safety of the public, but as a means to reduce the risks to the course of attrition and non-completion. At present non-completion of students on a course has the

potential consequence of a reduction in funding for student places by the LETB associated with the programme, with the concomitant consequences of threatening the job security of staff and the viability of courses if student numbers get too low. Therefore, these factors act as strong drivers for risk-averse behaviour and the reproduction of 'standard' students. This risk-averse behaviour is in opposition to the widening participation agenda within HE as a whole creating competing obligations and I believe that tutor uncertainty is often resolved in favour of the former rather than the latter. This creates a structure that appears fixed and the misrecognition that disabled students are a potential risk continues to replicate this structure, thus maintaining the environmental barrier. As previously discussed (see 8.4.1) this is particularly a difficulty for students with a physical impairment or health condition which may have an impact on a student's physical ability, because the physiotherapy doxa is so strongly linked to a physical corporeal standard.

Successful disabled students have the potential to change the physiotherapy doxa within their courses and the clinical environments in which the students complete their placements. Nonetheless, for this change to impact on the profession as a whole it is important that this success is shared. Pred (2003:124) called this process *distanciation*: stretching social interactions over time and or space to allow the benefits to facilitate change throughout the field. Neither the HCPC nor CSP representatives that I interviewed knew of any records of students who had been successful in completing their training as a wheelchair user. The CSP do collect disability information from physiotherapy courses, but again this is an administrative task and the statistics are not used to support disabled student education in anyway. The HCPC does not collate disability information, stating that the Equality Act 2010 requires justification on the collection of this data and they do not feel that the HCPC has such justification. I feel that the CSP, as the professional body, and as part of their Public Equality Duty, have a responsibility to not only collect this data, but to collate it into a useable form which would support the recruitment and retention of disabled physiotherapists. To this end innovative courses, which are challenging the boundaries of the physiotherapy corporeal standard, should be encouraged to

share their experiences by the CSP so that information is stored and disseminated throughout the professional organisation to facilitate admission of disabled students in other parts of the country. Such a system would need to be formally organised as opposed to the ad hoc posting of queries on the iCSP network already mentioned. I suggest that one means of organising the process could be the appointment of a member of staff responsible for co-ordinating the support for disabled students within all physiotherapy courses (Taylor 2005: Opie and Taylor 2008:298) and facilitating a nationwide meeting of these tutors, in the same way that the CSP organises meetings for admission tutors. This system would facilitate the sharing of current information, and the minutes of the meetings, made available via the CSP website, would act as a repository of information for future inquiries. It may also be linked to the existing CSP disabled members' network, which is a forum (physical and online) for physiotherapists and students with disabilities to meet and share experiences. The whole scheme would enhance the integration of disabled students as sometimes, although there may be an open and collaborative exchange between student and tutor, each party is unaware of how to resolve a particular dilemma. Accessing previous minutes or the resources provided by experienced disabled physiotherapists, within the disability network, may help to solve these situations.

The CSP disabled members' network does aim to provide mentoring for disabled students and the existing members are very eager to encourage more disabled people to attend, but it is not accessed by many students. One reason for this may be a lack of awareness of the availability of the network; only one of my participants was aware of this support group. Interestingly, this was Alison who displayed an affirmative orientation to her disability throughout the whole of this project. Other factors may include: location: the biannual meetings taking place at the CSP headquarters in London, which many students may not feel is accessible, although the CSP do fund the travel; timing: the meetings take place during term-time so students would have to get authorised absence from their courses and they would miss a day of teaching on their course, which may also dissuade them from attending, and finally self-identification: I propose that only

students with an affirmatory or situational identity would consider attending these meetings.

Environmental drivers, such as changes to policy and practices, do have an effect, but this is weakened by the self-replicating nature of habitus and structure. Environmental barriers will only be overcome when there are admission tutors and disabled applicants who possess the capital and habitus to break free from the doxa and are willing to take a risk, working together to address the students support needs. In Jackie's case, whilst the student was willing to accept the risk, the course was not (see 7.9.3 and 8.4). Yet, this too is changing with the recent admission of the wheelchair user mentioned earlier. There has also been a debate about supporting students with physical disabilities on placements on the iCSP network (Chartered Society of Physiotherapy 2015b). It is pleasing to see that some courses are able to think the unthinkable (Bourdieu and Wacquant 1992:40) and the postings on iCSP were very affirmative, not one of them suggested that the student should not be undertaking the physiotherapy course. However, it is important for these instances to be shared widely within the profession to facilitate structural change.

9.4 Structural Barriers: Change at a Societal Level.

9.4.1 Current structural barriers

During the course of my PhD studies the Olympic and Paralympic games were held in London. The high profile of the Paralympics at London 2012, and more recently at the Commonwealth games, has shown a more positive view of disabled people competing at the elite level of sport, but whether this is sufficient to transform the general doxa of disability was a topic that some of the students discussed in an online forum. Sally suggested that the media exposure of the 2012 Olympics would:

“make it more run of the mill and not ‘different’”

and Lauren commented that:

“the profile of disabled people has risen further than expected as a direct result of the games [everyone] loved the Olympics, but preferred the Paralympics”.

However, research into the impact of the Paralympics was less positive. Purdue and Howe (2012), Purdue (2013) and Braye, Dixon, and Gibbons (2013) all claimed that the image of the Paralympians has served to disempower disabled people in general society due to the reinforcement of the ‘Supercrip’ image, paternalistic representation of disabled people, and corporeal attunement to the ideal athlete image. In contrast research sponsored by Channel 4 (Channel 4 2012), whose coverage of the Paralympics won awards, suggested that 84% of respondents felt that the Games had improved society’s perception of disabled people in general. Although a recent report for Scope identified attitudes towards people are still overwhelmingly negative, with 58% of disabled people surveyed, a year after the Paralympics, commenting that they had not noticed any change in attitudes, with 22% of people suggesting that they had actually worsened (Aiden and McCarthy 2014).

Unfortunately, alongside the increased media representation of disabled athletes, other media portrayals of disabled people have been coloured by the “demonization” associated with the Coalition government and subsequent Conservative governments welfare reforms. The portrayal of disabled people within newspapers and on the television has become less focused on discrimination and more concerned with benefit claims (Briant, Watson, and Philo 2013; Runswick-Cole and Goodley 2015). Mattheys (2015) identified the major impact of the austerity measures on people with mental health conditions. She pointed to the paradox that whilst the austerity measures are creating increased pressures on the mental health of large sections of the population, creating greater demand for support, the cuts to services have resulted in only people with the most severe symptoms receiving intervention. Many authors (Morris 2011; Parker-Harris, Owen and Gould 2012; Goodley, Lawthom and Runswick-Cole 2014; Penketh 2014) accused the welfare reforms of being situated in the individual model of disability focusing on the person’s impairment rather than the social barriers against disabled people gaining employment.

Disabled students seeking access to a physiotherapy career have to position themselves as valuable potential therapists within this increasingly negative social structure. Consequently, I fear that this may have a detrimental effect on their success in negotiating entry into the profession. It is these structural barriers that lie entrenched within the doxa of disability, which replicate the barriers at the attitudinal level, residing in people's habitus; at the environmental level, within the field of power, and then again at the structural level. Consequently, I believe that to instigate a new system, change must be implemented concurrently at each barrier.

9.4.2 Social Change: Social Justice in Higher Education

As previously discussed, Gable (2014) created a framework for a meta-theory of disability, based on Bhaskar and Danemark's (2006) Critical Realist theory, which I adapted to justify my use of Bourdieu's theory of practice as a theoretical lens for my analysis of disabled students within the field of physiotherapy education. This framework may be expanded to explore the potential of an inclusive education system within HE and physiotherapy education (see table 9.1).

Epistemology	Models of disability		Factors affecting disability	Bourdieuian Analysis		Education system
Social Constructionism	Post-modern	Critical Realist	Cultural	Field	Struggle	Inclusive ↓ Individual needs
	Social model		Political	Habitus		
	Social Relational		Economic			
Psycho-social						
Empiricist	Individual model		Psychological			
			Biological			
			Chemical			
			Genetic			

Table 9.1: Comparison of models of disability, Bourdieu, and educational system (after Gable 2014)

In order to develop an inclusive education structure within physiotherapy, and HE in general, change needs to focus on cultural, political and economic factors. Unfortunately, as I have previously discussed (see 7.9.3), the current system is organised within the individual model of disability focusing on giving the disabled student reasonable adjustments in order to attune them to the corporeal

standard. Consequently, it may be seen as a one-dimensional solution to a multi-factorial problem. The following discussion will compare and contrast the existing system with a proposed social justice system which would provide learning support to all students irrespective of their dis/Ability.

The recent changes within the political system regarding disability include a move away from welfare and dependency to participation, equality and inclusion (Beauchamp-Pryor 2012a:254), as illustrated by the Equality Act 2010 incorporating disability with equality (Hyder and Tissot 2013:2). Yet the dominant ideology within HE is one of welfare and support (Beauchamp-Pryor 2012b:286), requiring diagnosis and categorisation (Boyd 2014:378) and equipping a student to negotiate barriers (Liasidou 2014:123; Penketh 2014:1487; Weedon and Riddell 2007). This perpetuates the individual model of disability which is failing students who choose not to disclose their impairment (Madriaga et al. 2011:615). Disability is multi-factoral (table 9.1) and therefore requires a multi-dimensional response from the education system (Bolt 2004:354). (Liasidou 2014:124) claims that an inclusive system would change the doxa within HE to one of participation, which is more congruent to social models of disability.

Inclusion, like ability, is a word which implicitly includes its opposite: exclusion and focuses on the individual. Current educational policy has expressed an inclusionary agenda, yet this is implemented by exclusionary, segregating practice: removing children from class (Hyder and Tissot 2013:10) and sheltered accommodations for examinations within HE (Bolt 2004:356). Therefore, the use of the term social justice would transcend this individual approach, being more compatible with a critical realist theory of disability, by focusing on multiple sources of disadvantage (Liasidou 2014:124) and changes needed within the institution and society (Hyder and Tissot 2013:11). One method of achieving this social justice agenda is by developing inclusive curricula. Universal design (UD) was first developed within architectural design to create barrier-free environments. Three different educational models have been developed from this concept: universal design for learning (UDL), universal

instructional design (UID), universal design of instruction (UDI), all of which incorporate principles of inclusive curricula; reducing barriers to learning and increasing access to the curriculum for the whole diversity of students (Rao, Ok, and Bryant 2014:153). Scott, McGuire and Shaw (2003) argued that the student population of HE is now much more diverse, with students from many different socio-economic and cultural backgrounds, who do not necessarily respond to the traditional methods of teaching and assessment. They emphasise the benefits of UDI to support this diverse and growing student population; there are no longer just a few students with impairments requiring additional resources and therefore a system which accommodates these students within the curriculum will be more cost-effective. In a recent systematic review of the three types of UD educational approaches, five empirical research papers evaluated the use in HE. The authors identified overall positive benefits for both staff and students of the adoption of UD, but counselled for caution as few of the studies included provided any causal link between universal design and student outcomes (Rao, Ok, and Bryant 2014:162). Although Simmons, Willkomm, and Behling (2010) offered empirical evidence in their study of the introduction of UD into occupational therapy education. One cohort of students was taught using traditional methods, whilst one was instructed with a UD approach. Both cohorts were assessed via examination and the results demonstrated a statistical significance between the two teaching methods, with students receiving UD getting higher examination marks, and also expressing high levels of satisfaction with this teaching approach. Most of this research is from America, where UD was originally developed. However, in my post-graduate certificate in education course, we focused on the consideration of multiple approaches to learning incorporating ideas such as Gardiner's multiple intelligence (Learning Theories 2015). We were encouraged to adopt a multi-modal approach to our teaching, which fits with the key principles of UD. Yet, I would suggest that whilst this teaching approach fits with the ethos of UD, the assessment processes do not, being entrenched in traditional means of assessment such as examinations and essays. I would suggest that incorporating inclusive assessment policies will facilitate a reduction of pressure on disabled students, who have already identified the effort that they commit to their studies (see 7.8.2). Within the current system these students are required to provide evidence of their impairment and to apply for reasonable

adjustments for their assessments months before these occur. In the HEI where I work the first year physiotherapy students have a formal examination in December, which requires the student to apply for their reasonable adjustments (citing module codes and titles) in October, when they are still adjusting to university life. If there were universally designed assessments this extra pressure would be removed from the students, allowing them to concentrate on their course.

Within physiotherapy education curricula design must also consider supporting student whilst on clinical placement. The participants in my study identified that this was a problematic area (see 7.9.3), with communicating their support needs being a particular issue. Botham and Nicholson (2014) developed placement learning plans for disabled students to facilitate better communication. It is my assertion that within an inclusive system these pre-placement learning plans should be completed with all students to facilitate their learning on placement; all students would benefit from a discussion of their strengths and weaknesses prior to commencing clinical practice. This process would be integrated into the personal academic tutor role as part of their pastoral remit. One codicil that Botham and Nicholson (2014:475) made in their report was that introducing this type of change requires support from the senior management team within the HEI.

The need for embedding of equality issues within the core institutional planning was identified in the report prepared for HEFCE on the provision for disabled students (Harrison *et al.* 2009:135). The authors suggested that this was the final stage in development within HE, which at best could be described as “an emerging development”. (Liasidou 2014:304) also recommends the need to address student and staff perceptions of inclusive pedagogy. I suggest that with the impending cuts to the DSA, proposed in 2014, but deferred until 2016 (Department for Business, Innovations and Skills 2014) universities will be forced into developing inclusive teaching and assessment. Lewthwaite (2014:1159) cited a cut of 70% of the total DSA budget with students who have dyslexia, dyspraxia

and attention deficit disorder having all their funding removed. The government itself has acknowledged that students with dyslexia are the vast majority of disabled university students: approximately half of the total disabled student population (Department for Business, Innovations and Skills 2014:15). They have also declared that the expectation is that only students with moderate to severe dyslexia (as measured by a post 16 educational psychologist assessment) will be eligible for DSA. Thus the vast majority of disabled students currently receiving an allowance will no longer be entitled to it in the new system. My understanding of the Equality Analysis undertaken by the Department for business, innovations and skills (2014) reveals that the government are applying the same neoliberalism to disabled students as they have applied to all the welfare cuts to this point. Students are now to be encouraged to be more independent learners in the same way as disabled people on benefits are being encouraged to independent and productive. The government are supporting these cuts to the DSA by citing the anticipatory adjustments expected from the HEIs and the Public Equality Duty, which requires universities to remove barriers and to promote equality in their policies and services (Beauchamp-Pryor 2012a:264). I assert that these changes to the DSA, which will be coming into action in the forthcoming academic year, will act as strong drivers for the implementation of an inclusive education system.

9.5 Implications of this work for the Physiotherapy Profession

The participants in this study made many recommendations to improve the system (Appendix Q). I have incorporated these with the previous discussion to make a series of recommendations for the physiotherapy profession as a whole (table 9.2). These implications fall into the three categories which build the SEAwall model of discrimination: Attitudinal, Environmental and Structural (Swain, French and Cameron 2003). Although the implications are divided into these different levels they are intrinsically linked and change needs to occur in all areas if a more socially just system is to be created.

Attitudinal Level	Environmental Level	Structural Level
Encourage disabled students to adopt affirmative orientation to their impairment and to act as drivers for change within their courses & placements	To make disability information more obvious on websites, providing affirmative information for prospective disabled students to include podcasts, case studies and disabled student journeys	To develop more direct links between UCAS, university and course pages for disabled students.
Encourage tutors to be more creative in their supporting of disabled students	To refrain from assessing a student's fitness to practise at admission, in accordance with the DRC report (2007)	To provide information packs for disabled students about the admission processes and different support available for them.
Increase disability awareness within the profession to reduce the negative attitudes towards disabled people.	To review the HCPC and CSP policies with respect to ableist concepts and the make them as descriptive and specific as possible, ensuring that the wording of competencies are sufficiently clear to confirm consistent application of these with respect to disabled therapists.	To use the PSED as a driver for change within HEIs, increasing the commitment of senior management to increasing the integration of disabled students.
Share good practice via physiotherapy courses, departments and the CSP to increase the distancing of successful experiences and support mechanisms.	Strengthen the work performed by the CSP disability network to provide ongoing resources for disabled students and therapists	To develop universal curricula to support the full range of diversity within the student body; in both teaching and assessment practices.
	Widen the physiotherapy corporeal standard via work on the norm (Winance 2007).	

Table 9.2: Implications for the Physiotherapy Profession

9.5.1 Implications at the Individual Level: Addressing attitudes of individual Physiotherapy Staff and Students

Attitudinal change is not simple as people's attitudes are an expression of their habitus which is the embodiment of structure. Therefore, to facilitate attitudinal change at an individual level within physiotherapy changes need to occur at a structural level within the physiotherapy profession. As identified in section 9.2 I maintain that the two key drivers for facilitating attitudinal change in physiotherapists involved with student education, both academic and clinical staff, are increased disability awareness and increased contact with disabled physiotherapy students or therapists.

9.5.1.1 Physiotherapy academic and clinical tutors

The process of integrating disabled students into the profession begins at the recruitment stage. Therefore the role of admissions tutor is a highly important

role when selecting the next generation of physiotherapists. Academic physiotherapy tutors, particularly admission tutors, need to be made aware of the physiotherapy corporeal standard and the potential subconscious bias towards professional corporeal attunement in the admission process (Allen 2004:494; Beattie and Johnson 2012). The previous discussion of the competing imperatives faced by disabled students during recruitment (section 7.2) indicates a need for academic tutors who are open minded, creative and able to “think the unthinkable” (Bourdieu and Wacquant 1992:40). Disability awareness training (section 9.5.2) would help to open minds and develop this creativity.

With regard to clinicians who support student placements the majority of student participants in this study acknowledged feeling less supported on placements. In this situation the culture of the NHS has to be considered (Hargreaves 2014:310-11) where the overriding concern is the patient, leading to disabled students’ needs being secondary to patient needs. As discussed in section 7.4.1, the focus for clinicians is treating patients, which leads to a focus on deviance from the corporeal standard needing to be ameliorated. A lack of experience in supporting disabled students may make clinicians feel vulnerable and anxious about these competing imperatives. Again disability awareness training would help to improve the clinicians’ responses to disabled students; they are not patients to be treated but colleagues who have much to contribute.

Although disability awareness is one means of achieving this I have already suggested that environmental drivers such as this are not as powerful as changes at the level of structure and habitus (section 9.1). In this instance a stronger driver for change is gained from working with disabled students and therapists.

9.5.1.2 Disabled students and therapists

The participants of this study recognised the importance of disabled peers being willing to discuss their experiences to encourage prospective students. Ironically, the majority of the students within this study also displayed a normative

response to their impairment (Darling 2003) and only willing to disclose on a 'need-to-know' basis. The information requested in the students' recommendations (appendix Q) requires students with an affirmative or situational orientation (section 4.5.2.1). These would be students who are open and willing to disclose their experiences to help subsequent applicants. Therefore, disabled students should be encouraged to realise that they have the potential to act as role models and advocates for prospective applicants.

Once a disabled student is accepted on a physiotherapy course and has disclosed their impairment they exert an influence on the habitus of the people with whom they work. Thus they hold a more powerful influence to change attitudes than disability awareness training as discussed in 9.2. Again the students need to be aware of this so that they realise that their presence within a course or clinical placement has the potential to improve attitudes towards other disabled students and therapists.

9.5.2 Implications at an Environmental Level: Changes within the HCPC and CSP

Both the HCPC and CSP have been identified as setting the environmental parameters of the physiotherapy profession (figure 8.1), especially in the codification of the professional standards. Thus both organisations have a role in implementing improvements to the system for disabled students. Whilst both the HCPC and CSP produced documents aimed at disabled students these documents were not accessed by any of the students who participated in this study. The production of documents and loading them onto websites may achieve legal compliance to the Equality Act 2010, but it is far from the affirmatory approach requested by the participants in this study. Nevertheless, the representatives interviewed from both organisations displayed a positive response to continuing to improve the integration of disabled students. In order to achieve this they need to develop environmental drivers to encourage the physiotherapy profession to become more affirmative towards disabled students.

9.5.2.1 Role of the HCPC

Increasing available information for prospective students was high on the agenda for the participants in this study. In response to this it is good to see that the HCPC's recently published document: '*Health, Disability and becoming a Health and Care professional*' (Heath and Care Professions Council 2015) is available on their website and highlighted on the student home page. There is also a video offering advice to prospective disabled students. However, the accessibility of this information needs widening. Many of the participants in my study did not know anything about the HCPC when they were considering physiotherapy as a career option. Therefore, the HCPC needs to make links with other organisations which the students might visit to increase the availability of this information: my participants recommended linking to the UCAS website. As previously mentioned the participants highlighted the importance of other disabled students as an information source (section 9.5.1.2). Consequently, the use of podcasts and blogs from disabled students on these webpages would show an affirmative approach towards disabled therapists.

The key barrier facing disabled students on admission to physiotherapy courses is the implementing of fitness to practise assessments during the admission process (section 8.3.2.2). In 2007 the DRC recommended that fitness to practise policies be revoked. However, a self-declaration of fitness to practise is still required from HCPC registrants. Although students do not have to register with the HCPC until the completion of their qualification programme, the HCPC require the courses to ensure the potential to meet these requirements during their training, resulting in health assessments during the admission process (Heath and Care Professions Council 2014b:13). This requirement needs to be removed from the standards of education and training, ending the assessment of health during the admission process. Students should be allowed to develop their coping skills over the course of their programme in the same manner in which they develop their professional skills.

Finally, the HCPC should review their policies and competency standards as an ongoing process to maintain their relevance to the profession and to assess the level of ableist language within them. The DRC highlighted that the more general the wording of a standard then the more potential it has to be interpreted in a way that leads to discrimination, either directly or indirectly (Ruebain *et al.* 2006:8). Therefore great care should be taken in the writing of the competencies to ensure that the language used is specific and limits the possibility of multiple interpretations, especially those which might lead to adverse disablism (Deal 2007).

As the HCPC regulates sixteen different health and care professions these changes could also be implemented across all of these professions. This would potentially greatly increase the presence of disabled HCPs throughout the NHS and private health care. This increased presence of disabled health employees would create a positive change on the habitus of their colleagues as discussed in section 9.2. Thus the extension of these recommendations across all of the HCPC professions will help to drive structural change.

9.5.2.2 Role of the CSP

Whilst the HCPC has a role in regulating the profession, the CSP has a role in the continuous development of the profession. To this end, it would be appropriate for the CSP to work on the dissemination of good practice by facilitating the sharing of positive experiences in supporting disabled students, whilst also addressing disability awareness training. The CSP could use the existing disability network as a resource to collate and share information on successful experiences (section 9.3). These might then be used in a disability awareness package disseminated to all areas of the profession. The awareness training would need to encourage delegates to explore the stereotypes, prejudices and adverse disablism experienced by disabled people in general by introducing them to the concept of the corporeal standard. Subsequently, this could be focused onto physiotherapy by examining the implicit physiotherapy doxa and introducing the physiotherapy corporeal standard.

9.5.3 Implications at a Structural Level.

If, as the saying goes “knowledge is power”, then more accessible information about the support available for disabled students would provide prospective students with the ability to explore their choice in a more considered manner. This could be achieved by linking between internet sites that have high traffic from prospective university students. As suggested by my participants, the most obvious of these would be the UCAS website, but could also include sites such as the national careers service and the NHS health careers websites. Each of these sites could contain links to the HCPC and CSP documents developed to advise disabled students on choosing physiotherapy as a career. Providing this level of information at this initial point of exploration would be offering the student the opportunity to consider their options without the pressure of having to decide about disclosing their impairments. If this information reinforces their desire to pursue physiotherapy as a career the students could then go on to contacting individual universities and courses. My participants also recommended that more specific support information could be provided by individual courses as an information pack which could include items such as, information about the DSA application process, getting your support package in place, advice from other students, and a list of useful contacts.

When considering the individual universities Harrison *et al.* (2009:135) discussed the importance of embedding equality within the core business planning of the institution, and identified this as an emerging process. As explained in section 9.4, the government’s neoliberal policy towards disabled students is directing the emphasis to address equality issues to the universities. The PSED will require university management to ensure that barriers for disabled students are reduced and reasonable adjustments to curricula applied. One of the ways in which universities can make their curricula more equitable is to implement universal curricula design (section 9.4).

9.6 A New model of Disability: The Ouroboros.

Many authors (Hemmingson, Gustavsson and Townsend 2007; Morris 2011; Williams-Findlay 2011; Liasidou 2013; Gable 2014) suggested the need to move society away from a neoliberal focus on the individual towards an inclusive society. However, this neoliberal policy with its inherent welfare reform is one adopted by the majority of G20 countries in response to the global financial crisis (Briant, Watson and Philo 2013:875). Goodley (2014:908) claimed that capitalism is broken, and rather than change the system these countries are attempting to repair it by reducing government spending, which is impacting on the most vulnerable members of society. Parker Harris, Owen and Gould (2012:826) cited the Organisation for Economic Co-operation and Development's (*OECD*) recommendation for a culture of inclusion, promoting wide structural reforms fostering capability rather incapacity. However, it seems that rather than focusing on these structural reforms the UK coalition government have focused on welfare reforms at the individual level. Mahatma Ghandi is quoted as saying "A nation's greatness is measured by how it treats its weakest members." (Education Innovation 2015). I suggest that a society based on social justice will demonstrate supporting its weakest members better than the current neoliberalism. The welfare budget may be unsustainable in its previous form, but alongside the changes to this the government needs to implement policies that encourage a more inclusive doxa towards disability, which would stimulate structural change.

Currently, the doxa of dis/Ability focused on the corporeal standard replicates barriers against disabled people in a perpetual cycle. Whilst considering the iterative nature of the construct of disability I remembered the Ouroboros. This is a legendary snake that eats its own tail. It can be found in numerous world mythologies depicting eternity, infinity or wholeness. It is claimed that our modern symbol for infinity derives from the Ouroboros. I suggest that the depiction of the snake in figure 9.2 represents the current replication of dis/Ability in our society. Disability and ability are both intrinsically, antagonistically, connected: one cannot survive without the other, yet they act in opposition. This situation is replicated by the iteration of habitus and structure throughout time.

Figure 9.2: Dis/Ability Ouroboros (adapted from anon n.d)

It cannot be interrupted unless by interventions that will effect change at the structural, environmental and attitudinal level. Legislation only serves to address environmental barriers, which perversely seems to reinforce structural and attitudinal barriers, for example the Equality Act 2010, and the status quo is maintained, although people may be more careful of their speech and actions to avoid being accused of discrimination.

When considering the individual and social models of disability these are also in direct opposition, the former claiming that disability resides in the person with an impairment: the latter identifying disability as being socially constructed. Alternatively, the critical theory model combines both of these models considering disability as socially constructed from multiple factors. Therefore to achieve a socially just society we must do “work on the norm” (Winance 2007:625) to actively change structure and habitus to include a greater diversity of people into the norm. This work on the norm would incorporate all of the factors which contribute to disability and in doing so would achieve equality for all. The Ouroboros would now be adapted to a circular representation depicted in figure 9.3 signifying the wholeness of society. My new conceptual model represents a society which focuses on a shared humanity, valuing diversity with a corporeal standard that incorporates and celebrates differences. Again this will be perpetuated by the iteration between habitus and structure, but in this instance attitudinal and structural barriers towards difference would no longer exist, and consequently, neither would environmental ones. In this type of society legislation would not be needed to drive or maintain the removal of barriers as discrimination would be non-existent: a society that would deserve the adjective ‘great’.

Figure 9.3: Society based on social justice (adapted from anon n.d.)

9.7 Summary

To improve the situation for disabled people, and disabled students in particular, change is required. Yet, this change must occur within the structure, field and habitus simultaneously to ensure a prolonged effect. The chapter commenced by considering the change that disabled students could facilitate at an attitudinal level by the process of regionalisation. This change can be widened to the whole physiotherapy education field by the process of distanciation, which the CSP could facilitate. However, change also needs to occur within the HE system to develop a more social model of supporting students, which an inclusive system would achieve. The implications of these changes were discussed from the individual perspectives of the physiotherapy tutor or student; the organisational level of the HCPC and CSP and finally the structural viewpoint of HE. To ensure that these changes are perpetuated structural transformation is required from a neoliberal system to an organisation based on social justice. This requires us to focus on our similarities rather than differences; as previously mentioned we need to emphasise a shared experience of humanity or human being (Dreyfus and Rabinow 1993:36).

Chapter 10: Conclusion: Different and yet the Same

*If people at least come away with the feeling that it **is** complicated,
that's already a good lesson to have learnt" [his emphasis]*

Bourdieu (1990a:52)

10.1 Introduction

Within this conclusion I start by presenting a brief overview of the thesis, identifying the gaps in the literature and the theoretical perspectives which prompted my research design. I demonstrate how I have answered the research questions by summarising the findings of my study. I then indicate my contribution to knowledge. Finally, I reflect upon how my study could have been strengthened and indicate further research potential based on my analysis.

10.2 Background to the research and gaps in the literature

The purpose of this exploratory study was to examine the integration of disabled students into the physiotherapy profession within England. The research was conducted from a constructivist epistemological perspective using a Bourdieusian analysis of the findings. Constructivism emphasises the importance of situating research within a socio-historical context. Therefore the initial chapters of this thesis functioned to fulfil this objective, giving a general overview of the construction of the concept of disability and also the integration of disabled students within HE and physiotherapy to date.

The corpus of literature exploring the experiences of disabled students in HE in general incorporates three large scale studies, which spanned the first decade of the 21st century, the time when the DDA 1995 was being introduced within HE (Fuller *et al.* 2009, Harrison *et al.* 2009, and Riddell, Tinklin and Wilson 2005). Whilst these studies considered the individual experiences of disabled students within a university setting their findings indicated a gap in the existent literature in studying the inclusion of disabled students at the specific subject discipline level. It was necessary to discover if there is any difference for disabled

students at this more local level of delivery, where the policies that affect disabled students are actually enacted.

When considering physiotherapy education, the complexity of the field was explained establishing the importance of physical capability within the professional context, a tenet that is reinforced by the definition of physiotherapy used by the CSP (Chartered Society of Physiotherapy 2014) and many of the HCPC and CSP standards being associated with performance of activities, which may have an implication on the acceptance of disabled people into the profession. The paucity of literature on the situation for disabled physiotherapy students or physiotherapists (French 1987, French 1988, French 1995, O'Hare and Thomson 1991) prompted a wider search of other professions regulated by the HCPC. This revealed literature concerning professional regulations, (Chih 2009, Forde 2009, Sin and Fong 2007), Sin, Fong and Momin 2008) professional education and practice, (Hargreaves et al. 2014, Sharby and Roush 2009)) and the experiences of disabled students or HCPs (Bevan 2014, (Murphy 2011), (Runge and Carnduff 2009), (Stanley et al. 2011), Sivanesan 2003). This exposed a crucial gap in the literature; there was an absence of research exploring the experiences of disabled physiotherapy students. It was evident that the voice of disabled physiotherapy students needed to be heard, especially as I was a non-disabled person conducting research into disability.

Disability is a complex concept (World Health Organisation 2002) which is not fully explained by the individual or social models of disability. The critical realist model was recognised as a practical model which helped to identify disability as being a result of many factors which might reside within the individual or society. However, although models help to describe disability they do not give us the means of exploring it. Thus it was important to identify a social lens through which to investigate disability. I selected Bourdieu's theory of practice (1977), as it considers the interactions between the person and their context using the concepts of habitus, field and capital. Bourdieu's theory is developed from empirical research making it a pragmatic approach for this study. It is hard

to classify Bourdieu into a specific theoretical perspective as his work is eclectic combining aspects of other perspectives into his theory of practice, which is one reason that it appealed to me.

Bourdieu emphasised the strong link between habitus and structure; habitus is structure embodied (Bourdieu and Wacquant 1992:135). Thus individual attitudes are developed from society and professional culture, both of which may include implicit barriers to disabled students. I aimed to explore these potential barriers in this research, by studying the policies and practices within the field of physiotherapy. To assist in identifying the location of these barriers I incorporated the SEAWall model of discrimination developed by Swain, French and Cameron (2003:2). This allowed me to consider my findings at the attitudinal (individual/micro), environmental (institutional/meso) and structural (macro) levels. The identification of structural barriers highlighted a need to explore the underlying assumptions about disability within general society and the physiotherapy profession, which may influence the expectation of disabled students being suitable candidates for physiotherapy.

10.3 Research Design

The three main research questions were as follows:

1. What are the lived experiences of disabled physiotherapy students?
2. How do the policies and practices within physiotherapy affect the integration of disabled students?
3. What information is available to prospective disabled students considering physiotherapy as a career?

Due to the disparate nature of my research questions I decided to adopt a crystallization framework for my research design (Ellison 2009). This approach recognises that there is no objective truth that exists, but multiple interpretations of the truth based on the interactions between the object and subject. Therefore, all accounts of research findings are partial and situated in a specific temporal existence. It also does not limit the researcher to one specific form of methodology or methods encouraging a more pragmatic blending of approach.

Using Mindful Inquiry (Benz and Shapiro 1998) as a methodology enabled a blending of phenomenology, hermeneutics and critical inquiry with Buddhist openness to the data. Thus crystallization, Bourdieu's theory of practice, and Mindful Inquiry are congruent perspectives to allow an exploration of the complex concept that is disability. My aim was not to uncover the whole truth, but to suggest the myriad of alternate perspectives and to indicate areas where the experiences of disabled students could be eased in future.

Firstly, the lived experience of the disabled students was explored by semi-structured narrative interviews with the initial ten participants, two of whom did not complete their degree and therefore only completed this stage. The remaining eight participants completed a Kawa Model, a second interview, and an online discussion. One symbolic capital that the participants shared was the perception of an increased empathic relationship with their patients. As this idea was also mentioned anecdotally in the literature (French 1988, Hargreaves *et al.* 2014, Taylor 2007) I performed a systematic meta-synthesis to locate evidence to support this perception from both the therapist and patients' perspectives. Secondly, the data on the information available for prospective and current students was gathered from within the participants' interview transcripts and from a survey of internet resources to establish the availability and accessibility of information to assist prospective students in their career choice. Finally, the policies and documents of the HCPC, CSP and QAA were investigated by a hermeneutic analysis and interviews with representatives from the HCPC and CSP were used within the hermeneutic circle to pose questions generated by the analysis and then to return to the documents after transcription of these interviews. The underlying themes and context of the profession were exposed by an iterative cycling between the thematic analysis of the documents and a Bourdieusian analysis of all of the collated data

All of the data collected was analysed using a critical narrative analysis process (Langdrige 2007:134) which included some of the contributors (Sally, Victoria, Alison and Lauren), acting as co-researchers in stage four to complete a thematic analysis of all of the interview transcripts. The themes developed were

shared and agreed between us and two of the co-researchers were involved in presenting our findings at the CSP conference in 2014 (Opie *et al* 2014). I then continued to analyse the data by interrogating the texts using a social lens; Bourdieu's theory of practice and the SEAwall model of discrimination. This allowed a deeper exploration of the data, uncovering the misrecognition, illusio, symbolic violence and discrimination present within the field of physiotherapy education, against which the disabled students struggle to create a position for themselves utilising their habitus and capital.

10.4 Research Questions answered

10.4.1 The Lived Experience of Disabled Physiotherapy Students

This study has offered the views of ten disabled students from four English universities on their lived experiences during their physiotherapy education. Generalisation was not the intention of this project, but there is a commonality of experience expressed by the participants which supports the discussion of disability being an experience rather than inherent in the person or their impairment (Goodley and Lawthom 2006:2). Disabled physiotherapy students have to negotiate their identities before, during and after their training. Since habitus is the embodiment of structure, students will have internalised influences from many aspects of structure into their habitus, hence, all students must be considered as individuals. The negotiation of their identity occurs against a negative background doxa towards disability being integrated into their habitus in a laminate system along with aspects of their individual biological and psychological profiles; socio-economic background; family reaction; schooling, and the specific physiotherapy assumptions within both the general public and also the profession. The negative doxa towards disability can be seen as symbolic violence, which is also replicated within the field of physiotherapy education. This symbolic violence was internalised by most of the participants within my research, who used negative words or imagery to describe the meaning of the word disabled. Also many of the students described physical imagery showing the internalisation of the physiotherapy doxa too. It can be argued that this doxa of physiotherapy is codified into the physiotherapy profession by the use of active verbs when describing the competence standards.

When considering the capital possessed by my participants, socially, they were representative of the bias of physiotherapy towards white, middle class females (Öhman, Hägg and Dahlgren 1999) and all possessed some cultural capital which could assist their transition into physiotherapy, either previous knowledge of HE or health provision. This cultural capital provided them with a feel for the game which Bourdieu (1990a:9) stated is so important for positioning within the field, and in the case of physiotherapy education in gaining entrance to the field. It could be argued that the assistance of cultural capital in accessing a place on a physiotherapy programme reinforces the social composition of the professional profile. Those students with an existing knowledge of HE or health-care are likely to be predominant within the middle class. This is a situation that the widening participation agenda is attempting to address within HE, but sometimes this is viewed with scepticism from tutors whose professional habitus is strongly linked to the illusion of maintaining professional standards.

Considering a wider definition of economic capital, the need for determination was identified as an important personal attribute for disabled students in order to succeed. This was eloquently illustrated by Lauren's climbing Everest metaphor, which I developed to acknowledge the effort expected from all physiotherapy students (embedded within the physiotherapy doxa: physiotherapists are hard-working) whilst illustrating the increased effort required from disabled students. This extra exertion is often necessary in negotiating environmental barriers within the normative system which is the basis for the current support for disabled students.

The most important form of capital within a field is symbolic capital; two aspects of which were identified as physical capability and interpersonal communication skills. The ableist attitudes within society are reinforced by the misrecognition that physiotherapists are physically fit, sporty (Greenwood and Bithell 2005:75), need to demonstrate physical capability in order to model this for

patients (Gibson and Teachman 2012, McKeever and Miller 2004:1185), and need to have sufficient physical capability to personally apply assessment and treatment interventions (Öhman, Hägg and Dahlgren 1999:59, Roger et al 2002). Not only does this misrecognition and ableism perpetuate the physiotherapy corporeal standard, but it also results in misrecognition in the application of physiotherapy standards and policies in the admission of students into physiotherapy programmes.

Interpersonal skills are highly valued within healthcare, which is also recognised in the current admission focus on values based recruitment (Health Education England 2015). Empathy is one of these interpersonal skills, which has often been cited as being a particular gift of disabled HCPs (French 1988, Hargreaves *et al.* 2014, Taylor 2007). The students involved in my research also indicated that they felt an increased ability to demonstrate empathy with their patients. A systematic meta-synthesis of the literature (Opie and Parkes 2015) supported the premise that HCPs with impairments possess emotive empathy that non-disabled therapists cannot grasp, but both groups of professionals may exhibit cognitive and behavioural empathy; although the expression of this higher level of empathy must be displayed morally i.e. to benefit the patient rather than the HCP (Morse et al 1992). The responses of the HCPC and CSP representatives to this notion of empathic consideration were guarded, expressing concern about the potential for homogenisation. However, I assert that this concern is based on the misrecognition that society must be based on semantic oppositional concepts used to delineate group membership. In recognising the extra effort required or empathy possessed by disabled physiotherapists we create the perception of decreased effort or empathy within non-disabled physiotherapists. However, if increased and decreased were not viewed as oppositional, but as markers indicating the full continuum of effort or empathy we would observe both disabled and non-disabled therapists occupying positions along the continuum rather than in opposition to each other.

On the whole, rather than this oppositional concept, the participants in my investigation emphasised the similarities between themselves and non-disabled

students. They acknowledged that entrance into the physiotherapy profession was difficult for all students and everyone had concerns and expectations at admission and also experienced highs and lows during their programme. These findings are supported by similar findings within research into the experiences of disabled students in the general HE population (Fuller *et al.* 2009:106, Madriaga *et al.* 2011:916), suggesting that irrespective of the person's impairment or the subject they choose to study they experience disability in a similar way. However, the strategies that they employ to position themselves within their respective fields will differ from person to person reinforcing the need for an individual approach.

10.4.2 The Integration of Disabled Students into the Physiotherapy Profession

The hermeneutic analysis of the documentation within the physiotherapy field using the SEAwall model of discrimination revealed barriers at all levels. At a structural level, the general doxa against disability is integrated into the field of physiotherapy. As the Equality Act 2010 codifies disability within the individual model of disability this is also replicated within the field of physiotherapy in its response to disabled students. Consequently analysis of the documents and policies exposes ableist attitudes codified by the use of verbs indicating physical enactment (deliver, use, undertake, apply, conduct, implement). Therefore, the codification of the disability doxa both within the HCPC and CSP policies can be seen as environmental barriers for the integration of disabled students. Although the policies addressing the competences and behaviours of physiotherapists might be viewed as reinforcing ableism, both the HCPC and the CSP have produced documents supporting the integration of disabled physiotherapy students. These documents were written with an affirmative approach, acknowledging the social model of disability. Although these documents were both available on the respective organisation's website, they were both fairly inaccessible, requiring the use of the search function to find them, which requires knowledge of their existence in the first place. However, none of the students involved in my research were aware of these documents, limiting their usefulness for supporting disabled students.

The processes for supporting disabled students mirror those within the wider HE system, adopting a normative approach which provides disabled students with reasonable adjustments to assist them to access their courses in the same manner as their non-disabled colleagues (Tinklin, Riddell and Wilson 2004:649). Some of the participants in this project, particularly Helen, identified that this approach is not always helpful, requiring a lot of effort on the part of the student to set up, learn and administer their support packages. For Helen this effort outweighed the advantages of becoming a physiotherapist and she chose to withdraw from her programme. Other contributors identified that whilst their support within the university was well implemented the experience within clinical placements was less positive. The students suggested that this difference in provision could be linked to a lack of disability awareness within the clinical educators, which was supported by Hargreaves *et al.* (2014). These authors also suggested that in clinical placements competing agendas exist between the NHS focus on the patient and the education of the disabled student.

These competing agendas also seem to exist within the HEIs when it comes to the application of legislation and policies at a local level. Whilst the policies are written by legal teams, which could arguably be claimed to be objective, they are applied by physiotherapy tutors who have an illusive to the physiotherapy field. These physiotherapists are the gatekeepers of the profession and misrecognise the physiotherapy corporeal standard along with the general doxa against disability which associates disability with dependence and incapacity (Hosking 2008:13). Therefore, prospective students who cannot attune to the physiotherapy corporeal standard are unlikely to be perceived as an appropriate candidate for physiotherapy, especially those with visible physical impairments and mobility problems. This was demonstrated by the reaction of the physiotherapy tutors to Jackie's acquired disability. The reasoning behind her withdrawal from the course was focused on patient safety rather than attempting to enable her to achieve her goal.

10.4.3 Information Available to Prospective Disabled Students Considering Physiotherapy as a Career Choice

The analysis of the information available to prospective students uncovered attitudinal and environmental barriers. Attitudinal barriers were highlighted by three participants (Alison, Claire and Sam) when they recalled limited expectations expressed by teachers and parents. This under expectation is also recorded by Liasidou (2013:306). Again this is linked to the general disability doxa, but also to the physiotherapy doxa and corporeal standard. In all of these cases the teachers or parents probably would not perceive their attitudes to be discriminatory, but to be protective, a response described by Deal (2007) as adverse disablism. I have also supported a disabled student in the past who experienced this adverse disablism when clinical educators decided that the only area of physiotherapy suitable for the student was research.

Environmental barriers included the ableism codified into the HCPC and CSP documentation previously discussed, but also information available on university websites. Many of the participants discussed the difficulty of finding out useful information on the support available for disabled students, other than generic non-specific anti-discrimination paragraphs, and certainly very little affirmative information. The review of websites conducted as part of my study indicated that this recognition by absence (Collinson, Dunne and Woolhouse 2012:866) extended across the sector, from UCAS to university websites and individual course pages. This lack of information not only made it difficult for the participants to gather material to help with their decision-making processes, but it also gives the impression that disabled students are not encouraged.

10.5 Contributions to Knowledge

My contributions to knowledge can be categorised at three levels: contributions to theory, to methodology and to the physiotherapy profession.

10.5.1 Contributions at a Theoretical Level

10.5.1.1 *A Bourdieusian Analysis*

As discussed in chapter five, the use of a Bourdieusian theoretical perspective is common within educational research. However, to my knowledge, based on my search, it has only been used twice within physiotherapy educational research, both times from the perspective of educators in Sweden and Australia respectively (Öhman, Hägg and Dahlgren 1999; Mooney, Smythe and Jones 2008). My research adds to this Bourdieusian analysis of physiotherapy education by providing additional data from England and providing the new perspective of disabled students. The previous research identified tensions experienced by the educators; my research demonstrates that these tensions also exist within the English physiotherapy profession, particularly when considering the integration of disabled students. Furthermore, this study identifies that disabled students also experience competing imperatives when negotiating their identity during their transition from student to physiotherapist. My Bourdieusian analysis of physiotherapy education within England has also served to expose the implicit doxa within the profession towards disabled therapists. An increased appreciation of these negative attitudes will allow the profession to introduce disability awareness training to facilitate the integration of disabled students.

10.5.1.2 *The Disability Ouroboros*

Another theoretical contribution is the use of the Ouroboros symbol as a visual model to combine the notions of habitus and structure with a critical realist view of social justice. This model is still circular, which Bourdieu identified as a misrepresentation of the relationship between structure and habitus. Yet, the Ouroboros is depicted as eating its own tail, which suggests a perpetual recreation of the snake out of itself, which I feel fits with Bourdieu's notion of habitus representing the embodiment of structure. From the perspective of the critical realist model of disability the Ouroboros indicates the social construction of disability: the snake recreates itself. In this process of recreation there is hope for an equal society where the concept of normal is applied to all people.

10.5.2 Contributions at the methodological Level

10.5.2. 1. *Crystallisation and Mindful Inquiry*

I have adopted a unique approach within physiotherapy by combining crystallisation and Mindful inquiry as methodologies for my research. The use of crystallisation as a methodological framework, and also an alternate means of ensuring the rigour of research, encouraged a higher level of creativity within the research design than using a more traditional approach. By amalgamating crystallisation with Mindful inquiry this creativity was enhanced by the imaginative variations required within the phenomenological turns of the spiral. Both crystallisation and Mindful inquiry fostered a deeper consideration of researcher reflexivity, which strongly linked to the reflexivity demanded by Bourdieu's Theory of Practice. I feel that physiotherapy research would benefit from the increase in creativity and reflexivity that these two methodologies offer as demonstrated by my study.

10.5.2.2. *The Kawa model*

Following the theme of creativity, I used the Kawa method as a data collection tool. The Kawa model is an emergent theory and its use within research is very limited (Nelson 2007). Thus integrating this model into my research not only provided the participants with an alternate means of documenting their experiences, but also has served to expand the knowledge of using the Kawa model within research. It has also functioned to introduce the model outside of the realms of occupational therapy to a new population of physiotherapy researchers.

10.5.3 Contributions at the Professional Level

10.5.3.1 *Physiotherapy Corporeal Standard*

I have developed the concept of a physiotherapy corporeal standard from the general corporeal standard proposed by Campbell (2001:44). On consideration of the relationship of these two concepts, I feel that the physiotherapy corporeal standard indicates the strong relationship between the structures within the field of power and the field of physiotherapy. The general corporeal standard is incorporated into the physiotherapy corporeal standard,

although I have established that the physiotherapy corporeal standard applies a narrower acceptance of physical capability based on the misrecognition of attributes required by physiotherapists (fit, sporty and physically capable). When this physical corporeal standard is combined with the physiotherapy doxa (hard-working and caring professionals) together they have a negative effect on the recruitment and retention of disabled physiotherapists. I have developed this idea throughout my thesis to explain the findings that students with physical impairments are subject to symbolic violence and discriminatory behaviour.

In order to integrate disabled people into the profession this physiotherapy corporeal standard needs widening. Initially, it is necessary to make this standard explicit to the physiotherapy profession, by increasing disability awareness, so that physiotherapists realise the hidden assumptions and adverse disablism (Deal 2007) within the profession that impact on disabled students and professionals. Then the CSP can work on the norm (Winance 2007) within council meetings, network events and the CSP websites to begin the process of widening the physiotherapy corporeal standard. Sharing of good practice throughout the profession would be an excellent means of working on the norm as it facilitates distancing (Pred 2003:124). However, in order to identify good practice more students will need to feel free enough to adopt an affirmatory orientation, being supported by tutors with more creative, open minds.

10.5.3.2 Fitness to Practise Policies

My second contribution to the physiotherapy profession is the questioning of the implementation of fitness to practise policies at a local level within the admissions processes to physiotherapy programmes. Disabled prospective students are assessed against the narrow physiotherapy corporeal standard and those with physical impairments are sent for occupational health screening. This screening applies the fitness to practise regulations to these entrants. I maintain that this application of these guidelines during the admission process is potentially discriminatory and against the Equality Act 2010 (s.60) which prohibits pre-employment screening for disability. The competency levels for physiotherapists are expected to be achieved at the completion of the

professional education, which should also be the case for fitness to practise requirements.

The application of fitness to practise policies during the recruitment of prospective students needs to cease immediately, as it is potentially discriminating. Instead, students should be given adequate information in a supportive manner in order for them to self-assess their own abilities against the physiotherapy practices that they observe during work experience prior to application. This information could be available on the physiotherapy course webpages and has been trialled by Cardiff University to assist applications in assessing themselves as suitable for being a physiotherapist (Cardiff University 2015). This could also be supported by information from existing disabled physiotherapy students in the form of podcasts, case studies or student journeys.

The HCPC and CSP need to review all policies, not only the fitness to practise policies. They need to ensure that all policies, including competencies or standards that may impact on the integration of disabled people within the profession, are not inherently ableist and cannot be interpreted more narrowly than intended. This may require breaking down some of the competences into specific requirements which are documented more clearly to avoid any ableist interpretations. With respect to physiotherapy education both organisations should encourage the development of universal curricula within physiotherapy programmes.

10.5.3.3 Competing Imperatives for Disabled Students

My third contribution at a profession specific level is a consideration of the competing imperatives that disabled students face when applying for physiotherapy. The current support system is fraught with dilemmas for disabled students, particularly associated with the negotiation of self-identity, which will then impact on their strategies within the field. A student with an affirmative or situational-identification orientation (Darling 2003:885) may be more willing to disclose their impairment, whilst a student with a normative response may be

more likely to hide their impairment in an attempt to attune to the corporeal standard. This passing behaviour (Lingsom 2008:2) will be more pronounced if the student perceives a danger of any potential discrimination or ableist attitudes within the physiotherapy profession. The recognition of ableism within physiotherapy led to a general reluctance to disclose impairments within my sample of physiotherapy students. The need to make these choices presents the disabled students with dilemmas, which are not without consequences (Lingsom 2008:2); not just through their training, but on into their HCPC registration and application for their first qualified position. I feel that these choices of response should not be judged as either positive or negative, they should be viewed in the same manner as individual coping strategies. I suggest that the adoption of a situational-identification approach may be the most pragmatic choice for disabled students, with disclosure occurring when the students see the benefits of disclosure being in their own interests. However this does not decrease the dilemmas for the students. Therefore a system is required that will allow students to adopt an affirmative orientation without any consequential risk.

In order to encourage disabled students to disclose their support needs more freely the current system needs changing from a normative scheme to one built on social justice. The recent proposed changes to the DSA and the PSED will serve to drive this change within universities. The government themselves have acknowledged that the reduction on DSA will have the greatest impact on students who have the diagnosis of dyslexia (Department for Business, Innovations and Skills 2014:7), whilst this group of students is also recognised as representing the largest number of disabled students within the HE system (Riddell, Tinklin and Watson 2005:79.) and also within physiotherapy (CSP representative #2). The reduction of DSA will therefore have a major impact on the provision of support for these students within HE. The government has emphasised the need to use the premium funding and PSED to make curricula more universal in design and have given the universities an extra year to make these amendments. I maintain that these requirements will result in an increased awareness of disability issues within the senior management teams of HEIs, even if only through an administrative response initially, which will hopefully change the

tone of support from grudging compliance to positive equality, with universality incorporated into teaching and assessment strategies.

10.6 Limitations of this Research

Whilst I attempted to access a wide range of students from across England within my research, I was only able to recruit ten students from four different universities. Seven of the participants were linked to the HEI where I work, whilst the other three were from courses with which I had no contact. It could be argued that this is a small number of students and universities from which to make suggestions for change within physiotherapy. However, Langdrige (2007:132) advises small numbers of participants due to the depth of the critical narrative analysis. Also the homogenous nature of physiotherapy as a profession (Öhman, Hägg and Dahlgren 1999:64, Opie and Taylor 2008:294) and similarities between my findings and those of other studies into the experiences of disabled students, such as Fuller *et al.* (2009), supports the transferability and authenticity of my findings.

Although I managed to recruit students with impairments that represented many of the categories described in the Equality Act 2010, I was unable to recruit any students with a speech impairment. This may have been a limitation of my population recruitment strategy, not being able to access all physiotherapy students via their course directors (not all course directors forwarded my request onto students) the student page of the CSP website (not all students are members of the CSP) and the limitation of the research to students studying in England only. It is important to include representation from all impairments, and the absence of a student with a speech impairment is regrettable, due to the symbolic nature of this form of capital. As previously mentioned, interpersonal skills are highly prized within healthcare professions, so this absence of a participant may have been because there are limited numbers of physiotherapy students with speech impairments. As identified in the analysis of the HCPC standards of proficiency (table one, Appendix O), the communication standard

may create difficulties for a student with a speech impairment, resulting in either not being recruited or not being successful on their course.

Another limitation of my participant sample was that they were all white, and the majority were females. Although I managed to recruit one male student, the ratio of women to men within physiotherapy profession is 4:1 (Health and Care Professions Council n.d). Yeowell (2013:341) identified that 10% of physiotherapy student entrants in 2010/11 were black and minority ethnic (BME) students. Therefore my sample of ten students needed two men and one BME student. The inclusion of these under-represented groups within the research would have allowed an exploration of the intersecting axes of oppression described by Hosking (2008:8-10).

Application to university is an important transition for disabled students and this research has failed to obtain data from disabled students who were not successful in this transition, by being dissuaded from applying due to limited expectations or by their application not being successful. This is an important omission as it would help to establish how the habitus of the unsuccessful students differed to successful students. This information could then have been used within the information for prospective disabled students to allow them to strengthen their applications.

It could be argued that the absence of the voice of qualified physiotherapists from this study is a limitation. However, it was never my intention to include physiotherapists, academic or clinical, within this project, as I felt that their opinions had already been sought in previous research (Atkinson and Owen Hutchinson 2005, Botham and Nicholson 2014, Hargreaves *et al.* 2014, Opie and Taylor 2008), whereas the voice of disabled physiotherapy students was silent. I was also mindful of the difficulties in attitudinal research which very rarely indicates actual behaviours. I felt very strongly that the student

voice should be heard and that this research should convey their experiences and perceptions of practices in the physiotherapy profession.

10.7 My Future Research Aims

Appendix R lists my past and planned future presentations and publications associated with this research. I have already presented sections of this study as five platform or poster presentations, both nationally and internationally. I have one paper in final draft form ready to submit for peer review and plan at least seven further papers. Furthermore, I plan to approach both the CSP and HCPC for an opportunity to visit and present my findings to the appropriate committees within those organisations.

10.7.1 Disabled Students

Whilst the data gained from my participants is supported by the general literature into the experiences of disabled students within HE, the sample population was limited, involving only ten students throughout the whole project. Therefore, it is important to continue to perform research into the situation for disabled physiotherapy students. I would like to expand my research to include students throughout the whole of the UK. This increased data would provide a stronger foundation to call for increased social justice within the system of educating physiotherapy students. This research could also be expanded to other professions regulated by the HCPC or who work within the healthcare system, such as nurses and medics.

10.7.2 Careers Advice and Prospective Students

As I have established, the image of physiotherapists is associated with physical capability, thus it is important to discover how this doxa affects disabled students who are considering physiotherapy as a career. Therefore it is important to determine the views of careers advisors, either by survey design, or by more personal approaches such as focus groups. The completion and distribution of the HCPC's new document for disabled student applicants would be an opportune time for this research to be performed, as it would increase disability awareness whilst also informing of the understanding of health professions as suitable careers for disabled students.

I also wish to conduct research with disabled students whose applications to physiotherapy were unsuccessful. I would complete this research using a similar research design to the one within this study. This would allow direct comparisons between the two groups of students. Exploring the differences between successful and unsuccessful students would increase the information available to future disabled students about their prospects of a career in physiotherapy.

10.7.3 Research within the Physiotherapy Profession

The identification of a physiotherapy corporeal standard within this research leads to more research into the implicit professional culture within physiotherapy. The exact extent of the corporeal standard needs investigating. I propose that this could be performed by designing a questionnaire which seeks opinions of the suitability of people with certain impairments as physiotherapists. I would select a questionnaire survey for this research as it offers a level of anonymity which may encourage participants to feel less inhibited than in interviews or focus groups. However, social conformity must be considered, even within a questionnaire survey design.

One of the recommendations from this research is to increase disability awareness within the physiotherapy profession. Once the extent of the physiotherapy corporeal standard has been established I would suggest introducing a disability awareness programme as an action research project. This would ensure that the current situation is audited prior to the change being introduced, potentially as a campaign by the CSP, which could be targeted at all areas of the profession, with a post awareness raising audit occurring to measure the change in attitudes, but more importantly behaviours.

10.8 A Final Personal Reflection

Benz and Shapiro (1998) suggest that Mindful Inquiry is not just a research process, but also a process of personal change. I agree with this and on reflection I have noticed considerable change in many aspects of my self-

awareness. Firstly, I have realised that I have an affinity for social theory which has developed from Marxist principles, which is probably why I found Bourdieu's theory of practice resonated with my life-view. I have become more aware of the nature of my own habitus and the dispositions that affect my social interactions. I sometimes find myself observing an interaction as if I were an impartial observer, assessing how I am using capital and strategies within interactions. The most significant of this increased self-awareness is my deeper understanding of Buddhist principles, particularly Mindfulness. Not only have I researched these with respect to this study, but also with respect to healthcare and personal development. I continue to use the Kawa model as a reflective tool and mindfulness within my personal life. I have also introduced both of these practices into my teaching to help students reflect and develop the emotional resilience to work successfully in the current healthcare system.

10.9 Overall Summary

Using a Bourdieusian analysis for this research has not only allowed me to answer the research questions posed at the commencement of these studies, but it has also uncovered the misrecognition, illusio and symbolic violence inherent in the physiotherapy field of education, the HE system and within society in general. The application of the SEAwall model of discrimination has demonstrated that there are structural, environmental and attitudinal barriers faced by disabled physiotherapy students throughout their education and on into their professional career. The recommendations made by the participants in this project are reinforced by those from other studies on the experiences of disabled students, which call for a more inclusive, universal education system. Learning support needs are not exclusive to students with impairments and as the student cohort becomes more diverse, more people will require a more diverse approach to teaching, learning and assessment. The ultimate paradox within physiotherapy is that it is a profession that explicitly associates itself with "maximising" and "enabling" patients to achieve (Chartered Society of Physiotherapy 2014), yet at times it appears limiting and disabling in its response to disabled physiotherapy students.

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Appendices

Appendix A: Ethical Approval

Ethical Approval for Student Narrative Interviews

REGISTRY RESEARCH UNIT

ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Joanne Opie **Faculty/School/Department:**

.....HLS/Physiotherapy.....

Research project title: The integration of disabled people into the physiotherapy profession

Comments by the reviewer

1. Evaluation of the ethics of the proposal:

The study plans to use purposive sampling based on a declaration of a disability on a UCAS form or from information obtained when contacting their HEI. Is this declaration not confidential to UCAS and the single HEI at which the student studies?

2. Evaluation of the participant information sheet and consent form:

Why are subjects from England only being approached, as suggested in the Participant Information Sheet Purpose of Study section.

Repetition in sections **Do you have to take part?** and **What happens if you take part and what you will be asked to do?**

If a subject decides to withdraw consent at any point will their data be removed from the study?

Typo you –to your in Possible benefits to taking part

In the section **Organisation and Funding of the Research** it states that Coventry University has no external funding, it is not clear how this relates to this study.

3. Recommendation:

(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

☐

Approved - no conditions attached

☐

Approved with minor conditions (no need to resubmit)

☒

Conditional upon the following – please use additional sheets if necessary (please re-submit application)

In section 8 there should be a yes tick in the second row down to reflect the possibility of emotional distress that is recognised in the comments section of section 8 and in row 6 of section 2.

Section 12 comments section refers to the use of an intermediary (course leaders) to assist in subject recruitment and states that “It is expected that this will ensure that participation is voluntary” how will this be monitored to ensure that this is the case.?

Also subject to amendment based on the comments in section 2 of this form.

☐

Rejected for the following reason(s) – please use other side if necessary

☐

Further advice/notes - please use other side if necessary

Name of reviewer: Dr Simon Barry.....

Signature:

Date: 14th Sept 2010

Ethics Approval for HCPC and CSP interviews

The following ethics request has been approved by Joanna Hemming. Please proceed with good ethics.

Ref:	P7763
Project Title:	An exploration of the accessibility of the physiotherapy profession for disabled people.
Applicant:	Joanne Opie
Supervisor:	
Module Code:	
Module Leader:	

Go to ethics.coventry.ac.uk to view this request in more detail.

THIS MESSAGE HAS BEEN GENERATED AUTOMATICALLY - PLEASE DON'T REPLY TO THIS MESSAGE

Appendix B: Participant Information Pack

CW216,
Charles Ward Building,
Faculty of Health and Life Sciences,
Coventry University,
Priory Street,
Coventry.
CV1 5FB.

1st August 2010

Dear Student,

You have been given this information pack because you have disclosed a disability. I am currently completing a PhD on the topic of the integration of disabled students into the physiotherapy profession. As part of this study I am hoping to recruit some disabled students at various stages of their professional education, throughout England. Would you be interested in being a participant in this study?

Please find enclosed an overview of the research proposal (feel free to contact me if you require further details). Briefly, you will be required to undertake two interviews (1 hour each), at the beginning (October 2010) and end (May/June 2011) of the academic year and to maintain an ongoing reflective journal, which would be suitable for inclusion in your CPD portfolio. You will be sent copies of your interviews for you to check (December 2010 & September 2011). I think you should be able to manage this level of contribution alongside your academic studies, but if you are finding it difficult then you are free to withdraw from the project: getting your physiotherapy qualification should be your priority. Counselling support will also be available throughout the project. All the information that you provide will be treated with the upmost confidence, for both you and your university.

I would be very grateful if you would consider being involved in this research. Once I have received your signed consent form I will send you more specific details of further arrangements.

Yours Faithfully,

Mrs Joanne Opie. MSc, BSc, MCSP, PgCert(Paeds), PgCert(HE).

Contact details: opiej@uni.coventry.ac.uk joanne.opie@btinternet.com

Tel: 07903 122411

024 7688 8884

The Integration of Disabled Students into the Physiotherapy Profession.

Previous research into disability within the physiotherapy profession in the UK is very limited, with only six articles within the past 30 years. Two articles examined attitudes or opinions of qualified physiotherapists. French (1987) studied attitudes towards disabled physiotherapists, whilst Opie and Taylor (2008) considered opinions about the admission of disabled students onto physiotherapy courses. Three articles discuss the experiences of disabled therapists (French 1988; O'Hare & Thomson 1991; French 1995), whilst Atkinson and Owen Hutchinson (2005) considered the challenges faced by visually impaired (VI) physiotherapists. As it can be seen the majority of these articles are over ten years old, with only Atkinson and Owen Hutchinson (2005) and Opie and Taylor (2008) published after the introduction of the DDA.

Purpose Statement

The purpose of this exploratory study is to describe the integration of disabled people into the physiotherapy profession within England. The research will be conducted from a constructionist epistemological perspective using a critical theory approach integrating a hermeneutic phenomenological methodology.

Key Concepts

This research will be underpinned by the British disability studies stance which is based on the social model of disability; disability being caused by physical and social barriers within society (Marks 1999). The study will endeavour to represent disabled people as a heterogeneous group with many different impairment diagnoses, but who all face overlapping experiences of disablement or exclusion (Goodley & Lawthom 2006 p.2). The terms 'disabled student' and 'disabled people' will be used throughout this study. This usage is favoured by the British disability movement. Although the social model places the concept of disability within the socio-political realm, this research is considering the integration of disabled people into the physiotherapy profession in light of the DDA and the Equality Act. Therefore, the definitions for disability and discrimination used will be those defined within these pieces of legislation.

However, it must be acknowledged that these definitions are entrenched in the medical and individual models of disability, where a person is disabled by their impairment rather than socially constructed barriers.

I am a physiotherapist who qualified in 1986. After working as a rotational junior and Senior II physiotherapist for a number of years I gained a Senior I position in learning disabilities (LD) in 1990. For the next 11 years I worked in LD and then paediatrics until moving into education in 2001. Working within these areas developed a strong interest in a more psychosocial approach to working with service users, children and their families. Recently I completed an Open University course: 'Differing perspectives on mental health'. This course emphasised the impact of social, political, environmental and economic factors on a person's mental (and physical) wellbeing. This has further strengthened my commitment to the importance of a psychosocial and person – centred approach to professional practice.

Currently I am a senior lecturer within a university in England. My main areas of teaching are pathophysiology, applied psychology, neurology and paediatrics. One of my key roles is acting as learning support tutor for the physiotherapy course, a role in which I am responsible for co-ordinating the support for any disabled students. When completing my MSc in physiotherapy I chose to use this role as a focus for my dissertation; investigating the response of admission tutors towards admission of disabled students and implementation of the DDA. The results of this study were published in *Physiotherapy* (Opie & Taylor 2008). Although I do not have a disability myself the years of working in LD, paediatrics and supporting disabled students have developed a strong interest in disability studies and I feel that this area has been a neglected area of research within physiotherapy.

Research Question

To explore the lived experiences of disabled physiotherapy students.

Method

In order to address the research question a number of disabled students will be followed through their qualification programme into their first clinical position. This longitudinal design will allow for exploration of issues with both the academic and clinical portions of the degree courses. It is anticipated that students will have a variety of impairments and be recruited from different qualification programmes and at different stages during their programmes. A number of methods will be used to gain data within this section. Semi-structured interviews will be conducted with all participants at the commencement of the study and then at regular intervals during the time course of the study. Interviewees will be requested to tell their 'story so far'. Alongside the interviews the students will be requested to make an ongoing record of their day-to-day experiences. This can be documented in a variety of ways depending on the student's preference, e.g. hard copy diaries, audio diaries, video diaries, computer blogs, story boards or using PebblePad. It is expected that the students will be able to use these ongoing 'diaries' within their CPD portfolios.

Participants will be recruited using purposive sampling from all qualifying programmes within England (46 courses in total).

References

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PARTICIPANT INFORMATION SHEET

Title of Research Study: The Integration of Disabled Students into the Physiotherapy Profession.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to consider whether or not you wish to take part.

Thank you for reading this.

Purpose of the Study

The purpose of this study is to explore the integration of disabled people into the physiotherapy profession within England. We will investigate the experiences of a number of students who are identified as disabled people by the definition of disability used within the UK government legislation (Equality Act 2010 and Disability Discrimination Act 1995). These experiences will be used to identify areas where improvements could be made to help disabled physiotherapy students in the future.

Why have you been chosen?

You have been invited to take part in the study as you have declared a disability or identified a learning support need either on your UCAS application form or when contacting your university course. These packs have been distributed to all physiotherapy programmes within England (the laws in Scotland, Wales & N.Ireland are not the same). The course tutors have been asked to give them to students who have declared a disability. I have been given no information about to whom these packs will be distributed, ensuring that your confidentiality has been maintained.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part and are a disabled student you will be contacted by the researcher to discuss how you would like to record your experiences. If you decide to take part you are

still free to withdraw at any time and without giving a reason, and your data will be withdrawn from the analysis. A decision to withdraw at any time, or a decision to not take part, will not have any adverse effect on your future relationship with your course, the physiotherapy profession or Coventry University.

What happens if you take part and what you will be asked to do?

If you do decide to take part and are a disabled student you will be given this information sheet to keep and be contacted by the researcher. You will be given the choice of how you would like to document your experiences, either face to face, by telephone, by 'Skype', or other means. You will also be required to maintain a reflective journal throughout the project and/or contribute to online discussions. Your reflective journal can be either a paper based journal, computer blogs or audio recordings, depending on your preference. You will be able to use this reflective journal in you Continued Professional Development (CPD) portfolio. Further consent will be sought prior to and following the submission of your journals and prior to release of findings.

Possible disadvantages of taking part

You may feel that completing the journal and/or contributing to the online discussions, doing your coursework and being a student might be a lot to take part in, all at the same time.

Possible benefits to taking part

Physiotherapists are reflective practitioners so to learn the skill of reflection through keeping a reflective journal will assist you in your CPD. It is also possible that your journal may be considered as auto-ethnographic data that you could use if your course involves a research dissertation module. It is also possible that taking part in the research might promote your own learning and insight into your learning style.

If new information becomes available

All participants will receive copies of data analysis and interpretation as they become available.

What happens when the research study is complete?

Findings will be published in a project report and more widely through academic peer reviewed journals or conferences.

What if something goes wrong?

If you have any problems with the conduct of the study please contact the Chair of Coventry University Ethics Committee Neil Forbes, for your worries to be investigated. Any complaints will be handled through Coventry University Complaints Procedure n.forbes@coventry.ac.uk

Will my taking part in this study be kept confidential?

In compliance with the Data Protection Act (1998) all information, which is collected about you during the course of the research will be kept strictly confidential. All information including digital recordings and transcripts will be coded. Electronic information will be password protected to ensure anonymity and paper copies stored in a locked filing cabinet. Recordings will be destroyed following transcription.

Research Findings

Findings will be disseminated through a project report, presentation at conferences and through written publication.

Organisation and Funding of the Research

The research is being organised by Mrs Joanne Opie from the department of physiotherapy and dietetics, Coventry University. I am receiving no external funding.

Review of the study

The study has been approved through the Coventry University Research Ethics Committee Medium Risk Research process.

Contact for Further Information

Should you require further information about the proposed study please contact Joanne Opie on 07903 122411, email opiej@uni.coventry.ac.uk or write to Joanne Opie, Department of Physiotherapy and Dietetics, Charles Ward Building, Coventry University, Priory Street, Coventry CV1 5FB.

Expressing interest in taking part in the Study

If you are interested in taking part in this study email Joanne Opie at opiej@uni.coventry.ac.uk and a consent form and further information will be forwarded to you.

Many thanks for taking time to read this information sheet.

JEO 08/10/10 Version 1

CONSENT FORM

Reference Number:

Title of Research Project: The Integration of Disabled Students into the Physiotherapy Profession.

Name of Researcher Joanne Opie

Please tick to confirm

- I have read the information sheet (Version 1 - 08/10/10)
for the above research study ☐
- I have had the opportunity to ask questions about the
research study, and to discuss it ☐
- I understand the purpose of the research study and how
I will be involved ☐
- I understand, and accept, that if I take part in the research
study I will not gain any direct personal benefit from it ☐
- I understand that all information collected in the research
study will be held in confidence and that, if it is presented
or published, all my personal details will be removed ☐
- I confirm that I will be taking part in this research study of
my own free will, and I understand that I may withdraw
from it, at any time and for any reason ☐

I agree to take part in the above research study

Signed _____

Date: _____

Signed (person taking consent) _____

Date: _____

Researcher (if different to above) _____

Date: _____

*1 copy for participant, 1 copy for researcher,

Version 1

Please tick your preferred means of delivery of documentation

E-mail ☐

Post ☐

E-mail address.....

Postal Address:

.....

.....

.....

.....

Appendix C: Request for Advice from Disabled Physiotherapists

▼


Your CSP Region

Your iCSP

Logout →

You are logged in as: Joanne Opie

Is anyone interested in contributing to my research in the area of disability?

 [Back](#)

Added by: j. opie
Posted: 04 May 2010 11:07

I am hoping to carry out some research into the integration of disabled students into the physiotherapy profession in light of the DDA & the new Equality Act. I would welcome some input from disabled physiotherapists on the areas/ topics that they feel the study should focus upon. I would also be very keen to work on a deeper collaborative level with anyone who is interested in this area.

I am a learning support tutor within the university system and have been supporting disabled students within academic and clinical education for some time now. In 2008 I co-authored a paper on a pilot study looking at the issues highlighted by admission tutors when considering implementation of the DDA into physiotherapy education. I now wish to look more closely at the whole process of becoming a physiotherapist from the perspective of the disabled person. The research is only in its early planning stage and I would be really appreciative of input from disabled members to contribute to the further development of the research.

Thank you for taking the time to read this posting and I hope that you might consider collaborating with me,

Joanne

Reply to this discussion

☒ Monitor this thread?

Appendix D: Topic List for Initial Narrative Documentation

Imagine that your life is an open book, take me back to whatever chapter you want to start from. If you want to go right back to chapter one and your early childhood and your background and then come up to date, that's fine.

- Why did you decide to apply to physiotherapy?
- What advice did you receive during your decision making?
 - Who gave you this advice?
 - Was this positive or negative advice?
- What is your background?
 - Family background
 - Educational background
 - Qualification routes
 - Types of schools attended
- Why did you choose your specific course and university?
 - Course content
 - Support offered by university
 - Student disability unit
 - Subject Learning support / disability tutor
 - ease of negotiation of the campus
 - Expected student experience
 - Location of university
 - Close to home – maintain social network?
 - Distant from home – declaration of independence?
 - Like the city/ town in which the university is situated?
- What do you anticipate the course will be like?
 - Coursework expectations?
 - Possible concerns about coping?
 - What are you most looking forward to?
 - What are you not looking forward to?
- Do you think your experience has been different to the students without any disability?
 - If so how?
 - If not why?

Appendix E: Letter to the course Directors of Pre-registration Course

CW216,
Charles Ward Building,
Faculty of Health and Life Sciences,
Coventry University,
Priory Street,
Coventry.
CV1 5FB.

Wednesday, 10 November 2010

Dear Course Leader,

I am currently completing a PhD on the topic of the integration of disabled students into the physiotherapy profession. As part of this study I am hoping to recruit some disabled students, at various stages of their professional education, throughout England. Please find enclosed some background information on the project and some participant information sheets and consent forms for disabled students.

Briefly, the students will be asked initially to document a narrative of their professional journey so far, in their preferred style (e.g. written, verbal etc). They will then be requested to maintain an ongoing reflective journal, which would be suitable for inclusion in their CPD portfolio and also to contribute to discussion forums online. There will be disabled physiotherapists contributing to these discussions and it is hoped that the forum will provide an informal support network for the students. If any participant reports that the research is interfering with their studies then they will be advised to withdraw from the project. Counselling support will also be provided to the students throughout the project. All the information that the students disclose will be treated with the upmost confidence from the perspective of both the students and the institutions at which they are studying.

I would be very grateful if you would consider distributing the accompanying information packs to disabled students on your qualification programmes throughout the whole cohorts.

Please feel free to contact me if you require further details.

Yours Faithfully,

Mrs Joanne Opie. MSc, BSc, MCSP, PgCert(Paeds), PgCert(HE).

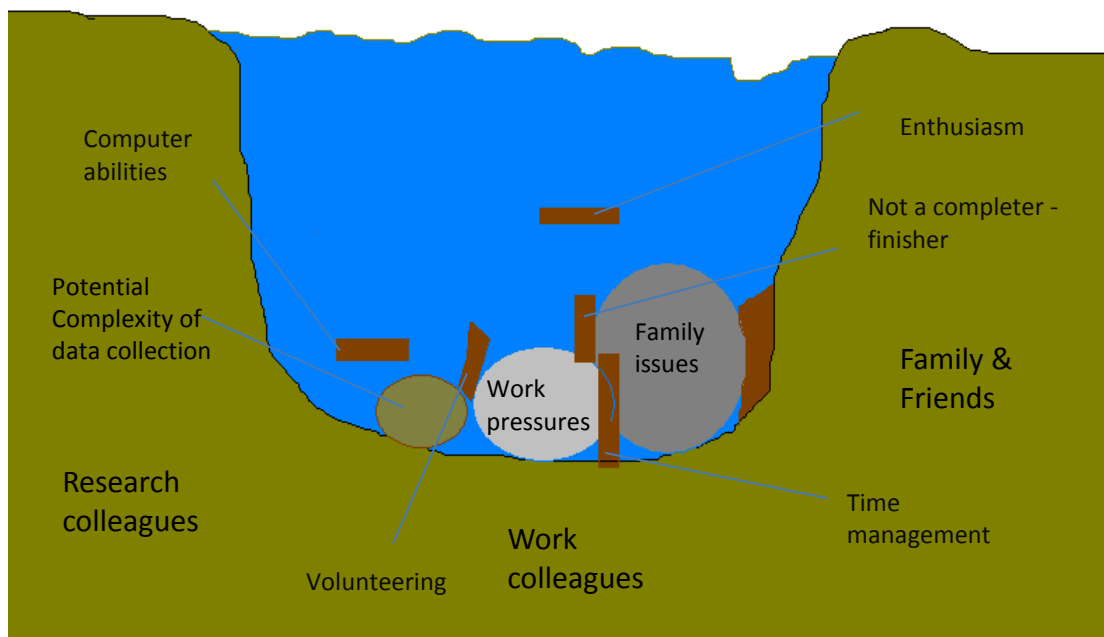
Contact details: opiej@uni.coventry.ac.uk Tel: 07903 122411

Appendix F: Participant Kawa Instructions

The Kawa model uses the metaphor of nature to encourage people to consider their life journey as a river (*Kawa* is Japanese for river) flowing from its source (birth) to the ocean (death). Our life journey is prescribed by our environment, both physical and social, which constructs the riverbanks (*Kawa no souk heki*) and bed (*Kawa zoko*). We also have life circumstances that affect our life flow. These are represented by rocks (*Iwa*) lying in the river. Other factors, such as resources or our own personal attributes, can also have an impact on our life flow. These are represented as driftwood (*Ryuboku*) and can be assets that help us displace or erode rocks or they can be liabilities that get caught on the rocks and river banks augmenting the effects of the problems created by the rocks. The person is encouraged to draw a cross section of their own river at a specific place in time, mapping out the interaction of rocks and driftwood with the river banks and bed. Within the OT context these cross sectional maps are then used to identify areas of intervention for the specific client. It is claimed that the Kawa model gives a truly client centred approach, which is not culturally exclusive, and can be used with individual clients, groups or whole communities.

Recording your Kawa Model

What I would like you to do is try to draw your life circumstances at present as a Kawa picture. To help you think about this I have produced a Kawa model for my PhD studies at the moment.



The round structures are rocks which represent circumstances that are inhibiting my studies as they are blocking the flow of my river. The family issues rock is against the wall of the river which represents my social environment, which is starting to 'silt up' due a reduced river flow in this area. The brown rectangles are driftwood representing resources or attributes that can help or hinder. Therefore, the attributes of not being a 'completer-finisher', having difficulties with time management and volunteering to help other work colleagues hinder my work on my PhD and therefore these get trapped with the rocks blocking the flow of water. However, my enthusiasm and computer abilities will help to erode or dislodge some of the other issues.

You can draw your Kawa model using paper & pens or a computer program (I used paint to construct mine): whichever is easiest for you. If you've got any questions about this drop me a line and we can chat about this. I'd like to get these collected in by the end of November.

Appendix G: Transcript and Narrative Summary from Jackie

Initially I was looking at students with a disability coming into physio, but when you got in touch with me I thought it's a great opportunity because one of the students I have already spoken to erm they had to withdraw off the course because of their disability erm and I thought it would be really good to talk to you and get you experiences.

Anything I could do to help sort it out would be brilliant.

Well what I've been asking student to do up until now is to just tell me their life history, but if we, probably with you if you just give me a bit of background as to why you chose physio and then go into what happened when you were on the course, is that OK?

Yes, that's cool.

Ok, over to you then.

Basically I was in the army, I was a combat paramedic and had always been looking at a possible profession, medicine, you know, and then basically I was reading and came across physio. So I went into [hospital] and saw what basically they were doing and it was just brilliant. It combined my sports coaching and my physiology with my medical skills so I spoke to the army and they said 'no problem' so in the August I phone [university a] 'cos they were showing they might have a space for that September, so phoned they said 'yep no problem' 10 minutes later had a conversation started with the army 'said no problem you can start in 5 weeks time'. So that was in September of 2007 and everything went fine for the first year. Erm, passed all my exams and everything else. Basically, then in the start of my second year in the end of October I was hit by a car on my motorbike basically with my legs under the car so was left in hospital. And erm, whilst I was in hospital I spoke at length to the university. The doctors weren't being very specific about what was going to be my future prognosis so I was doing the work for essays in hospital which in itself wasn't a problem. This kind of then became clear about December that I was going to be in a wheelchair and so of course then again I went and spoke to the university and the SEL [not sure if this is in the army] and they were umming and ahing and saying 'well you know you're going to be in hospital for a long period of time' and I said 'how about, if it would be easier for you then how about I just hold the year and restart year two in September?' so that was the plan, that was all sorted.

So in August I got a letter basically saying that [university a] needed to speak to me, so I phoned and basically got told that they didn't have the capacity to deal with me, at which point I was, you know, flabbergasted! You know, this was something that I was expecting to be able to work round together, you know. I know they hadn't and a physio on their course in a wheelchair before erm, but I,

you know, from the army, I suppose it's kind of turn up and see how it works and work around any problems. That's what I was expecting. They waited until 2 weeks before the year 2 started again to come back and say erm that they err we going to have to run all this through the OT department. Sorry, I missed some parts: In the August I'd come back from [unintelligible] and I said yes I got this letter. [unintelligible] and I thought right hang on get the picture about the course what do you perceive are problems? And after we'd talked through it so now they were still umming and ahing and not being very happy so I phoned [university b] erm and [they] after a half an hour conversation said absolutely, you can transfer into our year 2, no problems at all you know, we'll work it out with you. So then I phoned [university a] and said look I want you to transfer me to [university b] at which point they said 'oh, no, no we've been able to work through the problems and everything else and I thought it was all sorted so I said 'right OK in that case I'll stay with you' rather than you know mess about with the course might be slightly different and cover things in different order, some things at [university a] were in year 2 at [university b] if that makes sense?

Yes.

So basically I said 'right [university a] have got it sorted so great. Lets' stay here and carry on and I'll come back to the course at the end of September, which is when year 2 started. Two weeks before the course started I got a phone call saying that I needed to come in, so I went in and actually saw the head of year 2 and basically he said 'oh, well you know we don't have enough time to sort it all out' and I was like 'hang on you've known since last December that I was going to come back so why have you waited until 2 weeks before the course to now suddenly tell me that you've got all these problems, especially when I've come back to you after getting an offer from [university b] and promised me that [unintelligible] and he said 'oh, well there's two departments and this that and the other'. The fact that the health and safety of the patients is a higher priority than you wanting to be a physio, and all this stuff. And I said I would never ever want to put a patient in any danger but you know we'd spoken about all of this. You know, I thought you know you were going to work, erm, choose placements sensibly so it's not ' [unintelligible] anyway, he said 'OT need to see you' and I said I was just about to go on holiday for 10 days with my parents, which is basically a family time to get everything sorted after the, you know one of their kids ended up going from army running around every weekend on mountains to being in a wheelchair coming out of hospital, you know, so I was so miffed. And I said well look you can call me as much as you like, I'll have phone signal, but I promised to my family that I would be going. So they were' oh wel, you know, if that's more important than your physio career, it's not more important it's you've had a year to sort this out and now it's really unfair to leave it until now. So, basically, I said look get OT to phone me. There's nothing I can't tell them you know and then if they need to see me the first week I'll go in and see them. Heard

nothing for 5 days and after 5 days I got a voicemail left on my phone saying that there's no way that I could meet the things that the university had put in place and that I was going to be a health and safety risk to patients and other students and that was basically that, you know. I phoned up as soon as I got it and said 'what on earth's going on?' and I said 'look the Disability Discrimination Act says' and she said 'oh yes, well yes, but the Health and Safety Act overrides the Disability Act. Erm, so basically I got left in this ridiculous kind of situation. I phoned [university b] which then had a change of key person, who basically said what [university a] had said and turned around and said if [university a] have said that then that's you know obviously got to be the case. So I spoke to the physio, oh, what are they called, the governing body that covers...

CSP?

Chartered Society of Physio, and they were really kind of wishy washy about whether or not they could do this and then after speaking to them they said 'well even if we do manage to sort it, you know get sorted for next year then basically you are going to have all these restrictions throughout your career, you're never going to be able to go out as a sole physio you're always going to have to have this, basically an assistant who I have to tell her to do my job. You know, it wasn't the reason, you know it's the interaction with patients and it's the, you know, the problem solving response that you get from that hands on interaction that allows you to be a good, you know, practitioner. It's the same as being a paramedic. It's so difficult to do sat 2 metres away sat in a chair, you know. So basically then after speaking to several other people at the university, and at the CSP they were all kind of saying this thing that Health and Safety and that [university a] weren't happy about because of the health and safety issue that I'd have going forward placements to go on so that was it basically. Erm, I was told that I was withdrawn from the course and that it wasn't a career basically for people in wheelchairs, and that was that!

Right. So erm, you're talking about 2009/10 time?

It was 2007 I joined the course, 2008 was the start of my year 2. In October 2008 I had the accident. 2009 is when I was going to restart year 2 and basically it all fell apart from there.

So did you ever contact anywhere like the Disability Rights Commission or anywhere like that?

No I mean I spoke to, erm I went to like a citizen's advice bureau for the disabled and I spoke to a lady in there who said basically that if , the only way forward was to get, you know the heavyweights involved to start forcing it and basically was I erm you know wanting to cause massive problems. I felt like I was gonna be bringing the name of the physio and university down if that makes sense so again they kind of said well the Disability Discrimination Act is in place to stop this but

obviously it's pointless saying that disabled people can do every job, because that's ridiculous. You know I could be running round after criminals, over back fences, you know that's not going to happen. Erm, and yeah basically I was just kind of made to feel that there was this massive loop-hole in the system where people could get round the Disability Discrimination Act by throwing the Health and Safety Act at it. Erm, you know they kind of said well without a lot of hassle and a lot of erm, negative press on the course and on the degree programme that I really wasn't going to get anywhere so I then thought right then OK I've got to step back and think whether or not this is a. a good way to be spending my time and energy, which as you can appreciate being in a wheelchair there are lots of fights and you've got to pick your battles that are going to actually resolve in a positive way if that makes sense. Erm otherwise you're just constantly you know righting negative letters and stuff about yourself kind of thing so erm yeah, after talking with my parents and friends and so on they kind of said look get yourself as sorted as you can be and then you know decide whether or not it's something you can, that can be sorted out and that you, is it kind of worth the upset and time for me to spend fighting it. So it's just been left at the minute. Erm, yeah I didn't really know how to move forwards because it didn't seem that anybody was kind of coming forward says right yeah we can deal with this.

This is how we can work round it?

Yes.

So you know in your first year, did you do placements when you were in your first year?

No erm the placements were set for 4 weeks before Christmas, 4 weeks after of year 2 and then summer holidays between year 2 & 3 and then again Winter placements on the 3rd year.

Right, yes 'cos erm, there are, I know there are people who are qualified physios who have had accidents who have become wheelchair users who have been able to stay in the profession, but one of the arguments they use with regard to students is the need to be able to work in every area of physiotherapy.

Do they, when I suggested I went back with a list, back in the August when I was expecting to start again, I went back with a list of you know placements that I could work round and then suggest sort of ways that I could round placements that weren't necessarily going to be sensible. You know there's no way that I could walk and stabilise a stroke patient, you know and that's fine but you know there's always an assistant or whatever. The government will pay for you to have erm support in your job or in your studies to get into the job, you know and then once you're in it's [unintelligible] to pick, be sensible about no it's probably not best for me to go and work on a stroke neuro rehab unit. So yeah it was definitely going to be a problem but again as I said to them 'well look these students'- I had

picked up, could see the rota of where students were going, and what they were claiming was that everybody had to do this placement and that placement when actually when you looked down the list there was a whole host of different placements that people were going on, it wasn't just stroke rehab and outpatients, you know, and so I said 'well you know if I'd gone to that place, this place, this place then it would have been fine and this person's never been on the [hospital] rehab unit so why does it matter that I can't?' but they weren't having any of it. They said it would make things complicated and that I could be possibly be qualified and they started saying stuff about having to start year 1 all over again to prove that I could pass year 1 in the wheelchair, which you know it was as if every time I was talking to them about a solution I got 10 more problems thrown at me.

So there was no body sort of there willing to say to you 'OK [name] you want to do it, erm, we'll give it a go and if it works then great, if it doesn't we've all tried'.

No.

But then that was the impression they gave you initially when you first had your accident?

Yes, definitely and it was kind of they left me a morsel of hope right until it was too late to do anything else. You know, 2 weeks before you're suppose to be starting is not the time to be coming with you know massive issues when you've been speaking about it for the last 10months, but it's what happened and you know it just all seems that nobody was actually interested in trying to widen participation on the course. Erm, they just said they'd never had anybody in a wheelchair and that they contacted to CSP and the CSP didn't know anybody in the history that had even done this degree course in a wheelchair so I said that's well and good, but why is that the only reason why I can't try and do it you know. Just because no body else has tried or wanted to do it before was a nail in the coffin.

But actually I don't think the CSP keep that good records of how many disabled students there are on the course and what disabilities they have.

No they didn't seem to know exactly, but some guy he obviously told [university a] that nobody in a wheelchair had done the course before. Erm, because that's, well I'm assuming that [university a] wouldn't make that up, erm and it was something they were told by the CSP.

I know there's a student, or there was a student somewhere around [geographical area] who had [condition], but I think they were able to spend time out of their wheelchair, so they were, they used a wheelchair, but also were able to mobilise as well. So that might be, are you permanently in your wheelchair?

Yes. I can transfer, but I can't stand up at all.

And can you transfer up and down to the floor and back up?

Yes. You see I'm thinking, 'cos my background's paed's, so I'm thinking 'yes so you can't do an adult stroke ward, but couldn't you have done a paediatric neuro placement?'

There an outpatient department where they're mostly dealing with knees and it's mostly you know exercise and postural awareness and so on. There were load of different placements that I could have gone. They were very stuck on the fact that you know, the just kept coming round and round in circles to adult stroke neuro kind of place and you know as I said to them 'you wouldn't be my pick anyway, even if I had had to go to the placement I could have asked for an assistant or someone to come with me to stabilise the patient in a way. You know there are ways round these stupid rules and regulations about having to do the course you know. Erm, but then I'd done the placement, there you go that was a tick in the box and you know it would never be something you know I'd turn up to a physio employment interview you know and I'm not asked to tick something you know when there going to take one look and say listen you know we going to take this person and this person who can do the job more wholly and more, in a most satisfactory way, I was never going to win that place, you know and that's fine. Erm, because we all pick the person that's best for the job, regardless of disability you know.

So how did you feel at the time?

I just felt really, really messed about. I felt really discriminated against without being given the chance to even talk it through or try it you know or fail and I just felt that people were very unwilling to even listen to what ways round that I had, you know I mean I quite happily would have gone in you know and seen the course leader wanted to make sure [unintelligible], I was happy to come in and you know go through their worries and kind of discuss ways we could go round it, but I just hit a brick wall with no sorry Health & Safety and that was that you know.

Right so you mentioned earlier on about this, clash between the DDA or the Equality Act as it is now and Health and Safety issues; and they just kept playing the Health and Safety issue as like a trump card basically?

Yes they did. It just felt like a game where I'd come back and say well hang on you're not allowed to just use the fact I'm in a wheelchair you know fine, a physio course they assess and some people say that not being able to learn information is a disability, fine you know there are standards in certain professions that you have to meet you know and but just to keep getting 'we know that you're fine, you know all the information, you can study to the right level and learn everything else but sorry – wheels – that's it!' it's just ridiculous, but the more I spoke to them the more I just got this 'well you could endanger patients. You could wheel over

someone's toes!' and I was like 'well I could stand on their toes too!' you know I've never stood on anyone's feet so why should I wheel over them? But it all seemed like a game. They kept putting cards on top of mine and that was that! you know.

So looking back at it in hindsight how do you think they could have handled it?

Just to actually open up their kind of minds about things and just, even if they just discussed their worries, their problems, whether it's their perceptions you know it's, we could have sat down and talked through it all. Then even if at the end of it the outcome was the same I wouldn't have felt quite so 'no sorry you're now disabled, that's it!' you know there was nobody who was actually willing to look and even kind of say 'right well [name] actually you're saying this but this is the reason that we're concerned about it and this is why we can't work round it'. It wasn't. It was just no, no, no, you know and it was so difficult to get any exact or straight answers off anybody.

And was this just from the physio course or was this the disability office too? Did you get any support from them?

None. Basically they turned round and said that they could only offer support within the realms of what the course were able to, or agreed to, provide. So, the course had said no it can't be done so they couldn't do anything. Then they couldn't magic me a pair of legs. It wasn't 'cos they could put a computer system in place for me and that would solve the problem. It just seemed that there was no push from the students' disability services on the course either to actually stop and force them to at least come to a discussion or talk about it. They seemed to be very much run by the course itself. So if the course sent you because you had dyslexia and you needed printed notes and access to a computer system or whatever then disability services would then step in and offer that kind of thing that originally came from the course it seems to be told that they didn't have the capacity to deal with me as if I was a problem outside. It's not a particularly nice way to be spoken about, and you know, when I said to the lady I think you need to think about rewording that statement, she was all very oh, oh, er, er and I was like well there's the actual proof of how they actually feel about it. It was too much hassle for anyone on the course to actually be bothered to sit down. They all work long hours already and this is an extra hassle, they don't have the time, you know. They don't have the time to work around the health and safety issues. It was all about being basically a hassle to them. You know and that they fill that place with someone who wasn't such a hassle their lives would be easier.

Erm, what about your friends on the course, how did they react to this whole situation?

They were. It was very difficult I think because when the accident happened and obviously then I was in hospital for several weeks they kind of weren't told

anything, they were just told that I had had an accident and would be off and they, when I popped in at the beginning of 2009, erm, still within year 2 they were all right oh we thought you'd withdrawn from the course and we weren't quite sure what had happened, didn't know if you'd sprained your ankle or whatever you know. The course hadn't actually given them any information and there were some of them who had texted me obviously and I'd texted them back you know 'don't worry, you know, I've been hit off my motorbike, hopefully things will be fine.' It was that trying not to stress out and worry people that couldn't do anything to help, but the university didn't really kind of address it with them at all. So and then 'cos there were the ones angry that you know that I'd been withdrawn but they didn't want to upset the fact that they were still on the course. It was all very badly done. So yeah erm I mean I speak to a couple of them know who say you know that they just kind of said that I decided to withdraw off the course, which of course some of them know wasn't true. They kind of felt stuck in the middle, 'cos it was all very you know, it could have been handled so much better. I could have left with not quite such a bitter taste in everyone's mouths you know. Especially when you know I put hours and hours, you probably know the degree course is crazy, you know we had 30 or so hours of lectures plus we were supposed to do an hour of study for every hour of lectures we had, you know it's 60 hours a week or so and you put in all that time and effort through the first year and then yes it just all got cut.

You know you were saying you were formerly in the army, do you think the army would have handled it in the same way if you had still been in the army?

I was still in the army, I still am now. Basically, the army's problem was that I was, although they were paying me erm the NHS funded the place on the physio course and the army were paying me per day or whatever on the top of that for living expenses and so on. Erm, basically the problem the army had was that they were kind of stuck in a really weird position where it wasn't one of their courses it was an NHS funded course and that I was technically on study leave from the army so I was underneath the NHS and [university] not my unit and they were kind of left in a 'well we'll do anything we can to support you, but er you know we don't have power over the university course'. So they've been brilliant. I mean there's nothing that they can do about the fact that they can't employ people in wheelchairs because again as I said there are certain situations that disability is an overriding factor. You know there's no way that I could run away from people being shot or move fast enough and the buildings aren't wheelchair friendly so the army has put me on extended medical leave and I'll get medically discharged once they've sorted out their paperwork, but you know they were just so supportive and said you know look anything that we can do; if you need us to pick you up and take you to anywhere; if you want us to get some help in to talk to your family and so on. They were great in that kind of respect, but they couldn't get involved in university and the NHS and the fact that the student board or whatever actually

covers all the universities – I can't remember what that was called the register – what was it?

Oh the QAA?

There was some other body that kind of looks over or assesses all universities to see that their courses are up to the right standards and they have support in place and everything. But the army again couldn't kind of get involved and throw its weight around inside that system. It had no authority so they were as frustrated as I was over everything and the fact that they know that I wasn't going to be able to come back. I was a combat paramedic before I started the physio course and even as a physio [post injury] there was no way I was going to be able to start flying around in Afghanistan and places, even at [name of army hospital] it was going to be very difficult and I couldn't stay at xx for the entire of my career you know. I've now been in 9 years so they've been supportive but had their hands tied.

I think most physio paces in Britain now are NHS funded. You can't do a private physio course. So what are your career plans now?

I don't have any at the minute. Erm, I've been in & out of hospital and obviously going from running around on the course and I was training 20 hours a week sports-wise as well and army bits & pieces I was doing, you know going from that to in a wheelchair was a big shock and then getting dealt the blow with the course and everything was, left me in a bit of a flat spin I suppose. I've been looking at doing some, I just actually started a canine physio course, erm so dealing with animals who don't seem to judge me as much [laughs]. In fact they prefer the fact that I'm lower down.

More at their level.

Yes so I've just started that. Not with the university with a separate body and I've been doing some canine physio er with another course as well, a diploma course so doing those at the moment. It's really interesting. I've got a diploma for sports massage and injury from within the army and I'm kind of looking to do things, so I'm doing some canine massage. It is unfortunate, but humans are very judgemental. Lots of it's because of the media. When did you last see an advert on the TV with somebody in a wheelchair? Apart from the Paralympics you never see people with disabilities in the 'normal world' in shopping centres, in clubs you never see disabled people. So people do have a really strange view of what you're capable of and it was one of the other things that the university actually said that on the placement you know if some one didn't want to be treated by me then it was going to make them feel awkward and I thought well hang on they couldn't turn around and say no sorry you're Asian I don't want you to touch me, so why can they turn round and say you're in a wheelchair, and they said 'well you know patient's choice and patient's confidence' and all of this stuff. Again it's

a load of rubbish and it's because society in itself is very judgemental. It's a bigger problem than all of us see day to day until you end up in a wheelchair and then you wheel into a shopping centre and you get all these strange looks because you're by yourself, pushing yourself, you know and you're able to pay at a counter without needing somebody to count your pennies out for you. It's very awkward, but yeah I hope that the changes start from when we're kids and educating really young children that disabled people may or may not have the same mental, physical capacity as non-disabled people, but they've still got a sense of humour you know we still find it funny when occasionally we hit a kerb or do something stupid. People are very worried about how they're going to be perceived as acting towards you. They always go on the there, there dear let me do that for you or the other way which is to completely ignore you as if you don't exist. It's a mixture but it needs to start from way back down before the degree programme and every one on the programme.

Did you meet any of the OTs at all for this assessment?

No because basically then I got this phone call saying right the OT department are going to have to assess whether or not you're a danger to yourself and the students and stuff and then when I phoned back and said well what exactly are they going to be asking, looking for you know can I do the asking bit over the phone because as they know I was on holiday and it was all very much no they've got to see that your not.. and I thought hang on I was in with you 3 weeks ago. You've seen that I can control my wheelchair. It's not as if I'm crazy drunk wheeling around all over people. You know basically when I said to them what exactly do the OT want to confirm or look at he said basically to me that it was because the health and safety of the patients was going to be at risk and therefore they weren't going to allow me to start the course again but the OTs had to say so as well as them. Basically this was going to be a waste of my time [laughing] so I said to him I'd see them at the start of the year 2, I'd already done the first 7 weeks of year 2 so it wasn't as if I was going to miss something I hadn't already learnt. They weren't going to have it. I wasn't going to be allowed back into the university until it was sorted with them and when I basically got down to say to them well what exactly are you asking OTs to look at he said well whether or not when your wheeling round the campus whether you could lose control of your wheel chair and end up wheeling into a road. I was like what ! you could end up tripping and landing in a road. And he was very again, he wasn't OTs aren't going to look at these problems and resolve them with you it was right well we need them to say that you can't do it as well before we can not let you do the course properly.

So if I asked you to put your finger on their one main issue against having you back on the course what do you think it was?

Prejudice!

Right and I think you said..

Their mind was made up that somebody in a wheelchair could not do the job that they did. At points it was, you kind of got the people were trying to be really proper but eventually they slip up and you know one woman saying that they didn't have the capacity to deal with me, one of the other people said that I was going to be a liability in their sessions. I was going to be a liability 'cos I would have to transfer from my wheelchair to a physio plinth, and the joke was I was having to do that 3 times a day in my own time anyway for my physio! It was just lots and lots of little prejudices being built up without actually allowing their minds to be completely open and say right lets actually look at this and see what exactly, and I was willing to sit there and talk through every single learning outcome on the curriculum but again it was oh no she's not going to be able to do that without even asking or speaking to me or you know even considering actually whether or not they could do it if, you know as I said to them they need to get down and actually get into a wheelchair, instead of teaching us how to push wheelchairs around, get into one and see what you're capable of or not. You know there's lots of different equipment out there so I have a power chair that will take me up to eye level and standing. There's lots of things now in place.

Bizarrely the people on the animal physio course have been so open minded and they've been brilliant. I mean I was shocked. I came expecting to get you know the same kind of attitude and I didn't. they've been great at saying well this could be the problem, what do you think you could do to have a solution? I've gone away and then we've both come back together. They're really brilliant at being you know innovative I suppose but it's just being willing just to listen and say OK we get that you've got a passion for it and you might be able to work round things and if there are things we can't work round then we'll have to look at those at the time and decide if we can get you round it or if it's something we're going to need to get you past on the course, but really it's something you'd never do in your day to day therapy. They've been very openminded.

You know you were having physio at the time, did you discuss this with the physio who was treating you?

Yes. My anatomy and physiology at the time were brilliant, this is the other thing that we were talking about, that I'd managed to pass year 1 well into the 80%, yet there were people who were passing the course at 40. They were only doing 40% of the knowledge, I was doing 80 even with my disability, if that took out 10% of the stuff on the course then I was still passing a fair, you know it was a great frustration to her as a physio, because you know we were talking through my issues and you know I would come back to assessment and say look I think actually this is tight or whatever you know and she was great at allowing me to kind of carry on learning my physio you know [laughs] and she was very disappointed when it all got you know taken to this whole health and safety level. Erm and she said that you know if she could go in with me and talk to them about

stuff, she's been a physio for 24 years and that this is what she could see me being able to do, but again university weren't interested. They had people there with more experience, with more years and all of this stuff and they were saying that it wasn't possible. So, but they couldn't do it was another one of the statements that I kept hearing that they considered the fact that they'd been in the business 20 years and in a wheelchair they couldn't function as a physio to the standard. And it was like well you know we all have our positives and our negatives, you know, everybody has strengths and weaknesses you know they just weren't willing to hear it.

No I think as you say it's about the mind being open and the minute it's closed: I always say to students 'I can't do this I can't do that' are not reasons they are excuses. Every time you came up with a solution they came up with another, what they would say is a reason.

I felt like it was the fact that yes my wheelchair and the works around were going to take up a couple of hours more than other students. OK, fine, but I was willing to put in the work, but on the university side I was more hassle than you know the places where they could fill it and still get the same funding so they didn't really need the extra hassle. It would have taken somebody to take out a little bit of time to work through the issues, you know, with me, you know, I appreciate that there all lecturers, they're all manic, they're all stretched to the limit, but there must have been one person there who could give me an hour or so of their time to allow me to carry on, but unfortunately you know the get paid a set wage and if they don't have these complicated problematic students then it saves them an hour of their day, but you know it was, it was very evident and you know my Mum, my Mum's blind, she was born blind and so she's dealt with this her entire life and you know I've seen it from the wings as well my entire life and it does take somebody to say, 'you know what yeah it is going to take me and extra 5 minutes to go through this with you or to sort this out, but I've got 5 minutes, let's do it!' and unfortunately I didn't find anybody like that at the university.

Or there may have been someone there, but they were being outvoted in staff meeting or what ever.

Yeah. I mean I don't know if it was the staff with, there was a person there in my first year who'd been brilliant. I worked very hard to know all the information, but before exams got very nervous and she came up afterwards and said 'look you know if you want to talk about where you, especially exams where they're there asking you the questions and staring at you ,you know that kind of thing, that erm you know just to work things out and [name] was brilliant, but I never managed to get put through to her to speak to her about what was going on and try and find kind of like an ally amongst the staff. It was very upsetting in fact my family as well. I suppose when you're in it you kind of deal with it because it's your problem and so on, but when family are watching from the outside and you know you've

worked your arse off in the army and so on to get to be able to do this, then people just say no sorry, wheelchair, don't like it, but erm, yeah, every time you start to solve something your problems and that, the hassle, the effort outweighed the gains I think. Have other students had similar problems with courses?

Well I was thinking, with you saying that you Mum was blind. I was thinking that if in the accident your vision had been affected then you would have had lots of support erm from the RNIB unit at UEL 'cos of the history. I think that's one of the things, sensory impairment, blindness is very strongly associated with physio, but even then you hear physios saying 'oh yes, but that was in the old days and nowadays with all this new equipment and things it's less appropriate' and I just look at them and go 'Hmmm' and ignore them. It's my job at the university I work at to support the students with disabilities and I had a student not long after I started who had cochlear implants and I was new to the job and this was the first time that my colleague thought there had been any physio, and her teacher for the hearing said that this student 's the first person she knows doing anything as advanced as physio at uni. Erm, and I kept thinking how is she going to lip read in Paeds or neuro and I was having all these thoughts, but she was on the course and then I thought 'actually you know she isn't even there yet, so I'll worry about this when she goes out on placements, let's get her out and see how she carries on' and she was fine. I think that's one of the things. Reflecting back on that I think well I'm looking at it from a non-disabled perspective, somebody who hasn't got a disability and thinking 'I do it this way and how's she going to be able to do it?' but as you quite rightly said it's about thinking of how you need to adapt it.

Not necessarily how you need to adapt it but talk to the person who has the impairment. There having to adapt everyday.

Exactly

You know, what to you might seem a massive problem to them they're like 'oh well yeah I'll try this and if that doesn't work then I'll go onto this'. It's very difficult when you're not in the situation because you know unless you walk around as a blind person you know you're not going to know, how you'd feel and adapt to that. Basically, you know it always makes me laugh when places like hotels when they've gone to the effort of putting in like special doors for wheelchairs, but the you get to the doo and you've got a huge 8" step! [laughs] you know that's clearly put in because the Disability Act says you have to have this door in place, but haven't actually thought about it.

I think as well, physio wise, I think there's an acceptance of people with sensory impairment and an acceptance of students with disability, but when you get into physical impairment I think it's about physios' seeing themselves as a pair of hands and identifying their profession as hands and it's 'so hands on' and you

hear that phrase a lot and then if you can't get the hands on then you can't be a physio.

And actually there's such a massive range of things that you can do, but it does take you being in that situation for your brain to kind of work round and deal with those kind of issues and when you first look at something you know, even now in the wheelchair, I think 'Oh God how the hell am I going to do this?', but you know what's the worst that can happen? I don't manage to do it, even if I've been trying for an hour, but I might as well get on and try, you know.

Thanks for spending you time talking to me [name]. I'll transcribe this and email it to you.

Narrative Summary

This student was a mature student in the army where she was a combat paramedic and had research medical professions when she found physiotherapy which 'combined my sports coaching, physiology with my medical skills' and the army approved this decision. She started her physiotherapy course in September 2007. She was withdrawn from the course in her second year after having an accident which resulted in her becoming a wheelchair user.

Her first year was successful. At the beginning of her second year (end of October) she was riding her motorbike and was hit by a car, which went over her bike and her legs. This resulted in her being admitted to hospital and initially continued to complete written assignments from her hospital bed. The Drs were vague about her prognosis, but by the December it became clear that she 'was going to be in a wheelchair'. At this stage she communicated with the university and agreed to a temporary withdrawal to restart her 2nd year in the following September (2009). This plan was agreed to between her and the university. However, in August 2009 she received a letter that the university needed to speak to her, so she phoned them and was told that 'they didn't have the capacity to deal with me'. She was 'flabbergasted' as she was expecting to recommence her training and it would be something 'to be able to work around together'. She discussed the course with them to try to find out what specific issues they were concerned with, but they still seemed reluctant for her to rejoin the course. Therefore she contacted another university who agreed for her to transfer into

their 2nd year 'no problem at all, we'll work it out with you.' So she then informed her original university that she wished to be transferred to the other university. At this point the first university informed her that they had been able to 'work through the problems and everything else.' So she said 'OK in that case I'll stay with you'.

Then 2 weeks before year 2 started she received a phone call saying that she needed to attend a meeting with the head of department. The university felt that they did not have enough time to sort the situation out and that there would need to be an OT assessment and health and safety assessment. The university cited that the health and safety of patients was more important than her desire to be a physiotherapist. She thought that this had all been discussed previously and that they had agreed to 'work it through' and 'choose placements sensibly'. However, the university insisted on an OT assessment, but the students was about to go on holiday. She agreed to speak to the OT over the telephone. She finally got a voicemail message stating that 'there was no way that I could meet the things that the university had put in place and I was going to be a health and safety risk to patients and other students'. She contacted the university and cited the Disability Discrimination Act. The university replied that the Health and Safety Act overrides the Disability Act. She then contacted the other university that had offered her a transfer who had a new key person who now agreed with the original university. She contacted the CSP who were very 'wishy washy about whether they could do this'. They said that she 'would have restrictions throughout her career and would never be able to work as a sole physio, you're always going to have to have an assistant'. Essentially, the universities and CSP gave her the impression that 'it wasn't a career, basically, for people in wheelchairs'. She was then formally withdrawn from her course. Although she was on study leave from the army, and therefore still employed, there was nothing that the army could do to influence this decision as it was an issue for the universities and NHS. She feels that the main reason she was withdrawn from the course was 'prejudice': 'Their mind was made up that somebody in a wheelchair could not do a job that they did'. She felt that they were trying to be "politically correct" but that at time this slipped showing their true attitudes as demonstrated by being told that they 'didn't have the capacity to deal with me' or

she was 'going to be a liability in their sessions' because she was going to have to transfer from wheelchair to plinth (which she was doing weekly during her physiotherapy treatment sessions). The physiotherapists who were treating her at the time were willing to attend the university with her to discuss his opinion of her potential as a physiotherapist, but the university were not interested. She visited the citizen's advice bureau for disabled people and was advised that the only way forward would be to get 'the heavy weights involved and start forcing it and was I wanting to cause massive problems'. 'I felt that I was going to be bringing the name of physio and universities down.' She then thought that she felt that this might not be a valid use of her time and energy and she would have other battles to fight.

This whole process left her feeling 'messed about' and 'discriminated against'. She felt that people were unwilling to listen to her perspective and she just 'hit a brick wall of health and safety'. She felt that the reaction of the course and university was that it was all 'too much of a hassle' and they all worked hard enough already to be bothered with this extra hassle. She felt that in hindsight it could have been handled better if they had been more 'open minded' and be willing to sit down and discuss all of their concerns, problems and perceptions; 'if we could have sat down and talked through it all then, even if at the end of it the outcome was the same, I wouldn't have felt quite so: no, sorry, you're now disabled, that's it!' She feels that humans are very judgemental and a lot of this is fuelled by the media and society. There is very little positive portrayal of people in wheelchairs on the television for example (excluding programmes on the forthcoming Paralympics). This should be address at a young age in schools. Teaching children that 'disabled people may or may not have the same mental, physical capacity as ourselves as non-disabled people, [but] they still have a sense of humour...' She felt that if the physiotherapy course had a tutor who was willing to put in a little extra time to support her as a disabled student then that would have made all the difference.

She is currently undertaking an animal physio course, where the instructors have been really open-minded. They are willing to be inventive and discuss possible problems and collaborate on potential solutions.

Appendix H: Prompt Questions for Second Round of Student Interviews

- What did you think when you reviewed the other applicants' narratives and Kawas?
- What does the term disabled mean to you?
- What does the term disclose mean to you?
- Do you consider yourself to be disabled?
 - Why / Why not?
- Do you identify more with the concept of physiotherapist, student or disabled?
- Was your experience the same in university and clinical placements?
- Are you disclosing your disability on your job applications?
- What advice would you give to prospective disabled students wishing to apply for physiotherapy?

Appendix I: Transcript of Victoria's second interview

I: Yeah. Erm: So having looked at other people's Kawas and narratives...

P: Ummhum

I: ...Were there some that you thought really you felt that that a real resonance with you, or were there some that you thought I've never thought about that. Um what did you think?

P: I think the things that struck me about erm a couple of them, were having to do it alone. As in, you know what your issues are, you know how you feel you fit in nobody else can really understand so you kind of get on and do it yourself. Umm another aspect of it was not actually disclosing any of your real or unreal perceptions of what's going on in your life. Because, I suppose for the same reason, people can't possibly understand, or you might think you're in a minority and that there aren't any facilities to kind of help you or make modifications, erm and the other thing was about always catching up, feeling that your not in the same, we're on the same level as everybody else. That your kind of somewhere else. That was just one of the things, whether it is real or, or a perception. Erm. The other side to that was that actually by disclosing stuff you got positive responses, and may be a better response than you thought you would get.

I: Umm.

P: And that again goes back to your perception of nobody can understand, but essentially they can, if you give people the opportunity.

I: Umm.

P: Erm. I also thought that the ones that I read they appeared to me to be, people appeared more self-motivated.

I: Umm. This idea of determination?

P: Yes and whether that's because that's the type of person they were or because of what their perceived fear was that they had to work harder to to kind of I don't know that's.

I: Umm. Yeah that's the theme I've sort of picked out. Erm having to be that's sort of came across to me a lot, a lot of you were saying I want this and I've got to work really, and its hard work really, really, hard work, but I'm determined and I'm self-motivated I'm going to do it. That feeling of having to have that extra drive, it's all so much harder work.

P: Umm.

I: And this feeling of aloneness.

P: Umm.

I: Erm. One of the students er I don't know if you read that or I can't remember which one it is. Said that she, she used a lovely metaphor which I've actually used since, when I've been presenting some of my findings she said it's like climbing Everest in bare feet.

P: No I don't think I did no.

I: and erm when she said it I thought I like that and actually when I started preparing these slides, I I went I Googled Everest and there's two routes up Everest. There's the one that Mallory and erm no not Mallory, erm Hilary and Sherpa Tensing fencing did and the first full ascent which is both ways all ways up Everest are hard work but that ones slightly easier, more often travelled, and and they leave permanent erm scaffolding to help the people climb that route. The other route is less well travelled, er is a harder ascent ,but people still go that way and I thought Ohhh that works really well 'cos you can say, because discussing findings that's saying well for disabled students, or students with an impairment, or with an additional need, or whatever you want to phrase you want to use, its hard work and I get back from some other people well its hard work for all students.

P: Umm.

I: I think well yeah, but it's harder and so this this Everest analogy actually works quite well to say well, I'm not saying its easy climbing Everest isn't easy but...

P: Extra.

I: ..Yeah, yeah. Erm so that that worked really well. Erm and I definitely get the idea that its harder work and to do you've gotta be more motivated and determined. Erm I also picked up that disclosure thing. Interestingly, I was at a conference about supporting students with erm additional needs and they, somebody actually said the comment that 'well it's not surprising not many students disclose when you think of the word disclose because it its implying it's a secret' and it's something you ought to I don't know at at a level whether it's a level of embarrassment there about erm uggh I've got this additional thing.

P: I suppose it's like any, I'm just kind of thinking, it's like any minority isn't it?

I: Umm. Yeah.

P: You've always got to I don't know stand your ground or make a louder noise because it's, you are in the minority and.

I: Umm.

P: May be that makes it kind of less well understood or...

I: Umm.

P: Its its like the fear factor.

I: Umm.

P: For the unknown isn't it?

I: Umm.

P: Like things we don't like or are unsure of really.

I: Yeah, yeah. Do you think with the beautiful presence of hindsight, looking back, would you do things the same or would you do things differently? I mean you were in quite a, it was a really compact time frame for yourself wasn't it? This sort of decision and getting on the course it was all really quite rapid [laugh] but if you if you were talking to a student erm or somebody, say when you're working and you have someone coming around and they say well you know I want to do physio and I've had a bout of depression and I'm not sure I'll, it'll be good for me. What would you advise that student?

P: Erm I would say just get on and do it.

I: Umm.

P: Because and I don't know if this this general for people who've had depression or mental health issues or if it's me and my decision making process.

I: Umm.

P: Ermm I I I think sometimes its possibly the depressive element of you analyse stuff so much and you think about it so you can talk yourself out of doing it.

I: Out of doing it? Umm.

P: And I think that is a kind of a depressive trait.[Clears throat]

I: Umm.

P: So I think it's a case of if you think of something and you think it's a good idea for you stop there. [Laughing]

I: Don't over think it?

P: Yeah.

I: Umm.

P: And I know one of my erm are they criticisms?

I: Umm.

P: Is that I think about things too much.

I: Umm.

P: And I think you can, you can analyse and analyse until you know the end of the world, never make a decision, and actually never do anything.

I: Umm. Umm.

P: And I've notice a couple of times for example filling in forms and I'm like ohhh shall I put that, or shall I put that?

I: Umm.

P: Right ok let's just do this form and get it out the way so to answer your question [laughing] I would I would do exactly the same thing.

I: Umm.

P: Which now you've asked the question I think is quite a positive thing because generally hindsight will.

I: You say change something? Umm.

P: Actually do something different.

I: Umm.

P: Because erm I think I would think about it to much.

I: Umm.

P: You find a lot of reasons for not doing it.

I: Umm.

P: A lot of possibly valid reasons for not doing it and, you know, I can only speak from my specific experience.

I: Umm.

P: It's probably the best thing is to get in a do it and you know the old adage of facing your demons because.

I: Umm.

P: You will, we avoid human nature is to avoid what is not good for you.

I: Avoid Umm.

P: From a developmental point of view erm and sometimes you just have to say okay I don't like this not very comfortable with it.

I: Umm.

P: Do it.

I: And what would you say advise them about mentioning their mental wellness to people?

P: I would again do exactly what I did.

I: Umm.

P: Is tell those that need to know.

I: Umm.

P: Erm from from a point of view of your own erm you know being able to discuss it with people whom.

I: Umm.

P: Are in a position to understand and for for kind of legal or safety reasons erm but I wouldn't disclose it to my fellow students.

I: All and sundry.

P: That is potentially an age issue.

I: Right.

P: And potentially just a general, some people can appreciate.

I: Umm.

P: What you're saying and some people just can't.

I: Yeah.

P: And that's just a human nature thing as well.

I: Yeah, yeah.

P: And I think it would, not damage the kind of environment you're in but.

I: Umm.

P: I suppose one of my problems was not wanting to be 'oh she can't do that because'.

I: Yeah.

P: You know, if you start on a level playing field, even though your potentially not.

I: Umm.

P: Erm its like you can give yourself lots of excuses for not doing things.

I: Yeah.

P: Not make it easy but sometimes, and particularly with depression, I know a kick up the backside is not going to work for everybody. But there is that danger of it takes over.

I: Umm.

P: Can't constantly do that because, that's a dangerous and that's why it's a really difficult thing to...

I: Yeah, yeah.

P: ...Have like a decisive answer on and that's why I think everybody is so different.

I: Yeah but interestingly your talking, I'm listening to you talking and I'm thinking of the student with Rheumatoid-arthritis who was saying, you know, one day I'll be fine the next day, if I'm having a flare up, I'm may be can't get out of bed.

P: Umm, Umm.

I: Having to use err crutches or, or maybe even a wheelchair, and what are people going to think of me?

P: Umm.

I: Umm and it's a similar sort of background issue as yourself you know.

P: It is, it is. Having to not deal with what's going on, but how that's going to be responded to.

I: Yeah, yeah.

P: Erm so I guess they're all the same in that in that kind of respect and, and **it is** [emphasis] how you perceive it.

I: Yeah, yeah.

P: And how you deal with it and that goes to the thing about [clears throat] everybody's so different.

I: Umm.

P: And you know if you've got an RA group, or a depression group, or something you can talk it over with people.

I: Yeah.

P: It's still that group and the general population, the student population, whatever, you know you're still kind of catching up, I guess.

I: Umm. Do you think if there was more, erm, it's like one of the students said its not that out there there's negative, any negative attitude towards students with impairments applying, it's the fact that there's nothing positive out there, that made her decide not to disclose. Do you think if there was some information out there that says, you know, physiotherapy is a potential career for people with impairments and it's all decided on an individual basis and may be some erm...

P: I think it might help if it was erm kind of advertised in.

I: Umm.

P: In a in a positive way as opposed to just not mentioning anything at all.

I: Yeah, yeah. That disclaimer, little disclaimer paragraph thing that says its all judged on an individual basis. My idea is to get a few, erm video you know if you go on to our website you can go to some student videos that say come to xxxx University I'm here I'm studying this. I want to try and get some students with impairments to say, 'I'm on this course', erm over the whole HLS, not just physio, just to its there for students to access and go 'ohh there is potential to go into nursing go into physio, OPD, para' well paramedics you have to do a physical

thing er test to get on er we so far with regard to the university in general we've actually now got on the blue site under the information for students the thing that says information for students with disabilities which brings all the information together 'cos it's really hard to find anything on our website erm you know if I was trying, can't find the student welfare number, it takes you 5 minutes to find it erm

P: (Clears throat) And also if its if its more prominent there.

I: Umm.

P: It's not just for the students with a n other condition.

I: Yeah.

P: It's more noticeable for everybody and then it's not just like an add on like you know we respect all faiths.

I: Yeah.

P: And and opinions you know it's like the standard thing tucked on at the end if it's more part of the whole kind of university persona.

I: Yeah.

P: Erm. Its more into the main stream. I mean all these things are kind of just like tagged onto the end.

I: Yeah, yeah.

P: And and may be getting. you know. students to understand more. it is about understanding.

I: Yeah.

P: And the fear of the unknown.

I: Yeah.

P: You know if some people fear people because they speak different language and they can't understand, it's not that they don't particularly like them, it's just that they don't know what they're saying.

I: Yeah, yeah. Do you think it's also, I'm trying I'm looking at this sort of thinking theory wise trying to think of how it ties in theory wise, and I've been doing some socially reading, and some psychology reading, and some social psychology reading [laughs]. Erm and erm one of the things is, is I've I come across that I think might be playing out here is, I don't think anybody that I've, I've interviewed so far has said 'Yes I see' oh one student has said 'Yes I do see myself as having a disability, but I see myself as being an athlete. A certain percent as an athlete, a certain percent a physio student, a certain percent having a disability and disability having the smallest percentage, but then otherwise everyone else said 'No erm I didn't disclose because I didn't think I'd got a disability'. Erm and comments like that and I'm wondering if that's about status groups, and the fact that people are referred to as '**The Disabled**'[emphasis] is an idea of it being a fairly low status group, erm and yet physio is, would be a higher status group so your aspiring and hooking up to the term physio..

P: I would agree with that 100%. You know if 'I can say I'm a physiotherapist I am not x'.

I: Yeah, yeah. And the other thing is, and I think it links in with your idea of fear the unknown and its about belonging and you were talking about, in essence what you've been talking about is within your peer group, you don't want to be seen as different and it's about belonging to the group, and being accepted and part of the group and not wanting anything that might make the rest of the group go oh no you're not with us erm so that's an interesting issue that's going on as well I think.

P: It's it's about erm kind of the power of the group as well isn't it.

I: Umm, yeah.

P: And the, you know, getting back to the minority.

I: Yeah.

P: Erm. You know if 95% of the population was disabled or had some impairment, or whatever you want to call it.

I: Yeah.

P: It would be fine and hunky dory.

I: Yeah.

P: But erm.

I: Because its only 10% yeah well its more than that but that's the the percentage they band around there's got to be a higher level of hidden disability on top of that hasn't there. So if, what does the word disabled or disability, conjure up for you in your head?

P: Erm [clears throat followed by a slight pause] being cut off from, erm what's the word I'm looking for, erm [clears throat] participating in, or having the choice of participation, and being side-lined, being catered for.

I: Right.

P: As opposed to just getting on and doing what you want, and there are all the facilities that are **non-disabled** you know the word, you're dealt with your not just kind of.

I: So it's passive?

P: I think so it's, it's the group and it's the power and erm you know the group is doing fine just kind of trudging along and we'll help the disabled.

I: Yeah. Yeah so it's a very passive negative sort of label.

P: Ummm.

I: Yeah, and if, what sort of person pops into your head when you think disabled?

P: I think historically, because I suppose my generation, you know, that that the changes over the last 10, 15, 20 years have been quite, I wouldn't say massive, but ther've been changes. Whereas, you know, from my kind of early schooling and childhood disabled meant physical inabilities to to do, erm, plus I think now I'd probably think of it more as a bigger umbrella that covers a lot more things, but I think I'm discussing, if you said disabled to somebody it would just be can't walk, or they can't talk, you know something a physical thing.

I: Yeah, yeah.

P: As opposed to.

I: May be a physical or sensory impairment as opposed to dyslexia or mental well-being or things like that.

P: Yeah, yeah.

I: Yeah I think your right, and I don't think the sign helps with it being a wheelchair user.

P: And even, even the word it's, you know.

I: What have they changed it to in America? Differently abled.

P: It's still got the abled.

I: [Laughter] Yeah, yeah.

P: Di- which you know is negative.

I: Differently abled, erm or other abled .

P: But then that goes to the point where we have to put them in a group.

I: It's still labelling.

P: It's still the group over there isn't it?

I: Yeah, yeah.

P: We're happy.

I: This is us and that's them. Yeah, yeah. Erm. Would you say when you were talking about your positive experiences, so you know actually, once when you disclose its all been quite positive, do you feel that the reaction within the university and without the university has been the same. [Pause] Er I mean clinical.

P: I think the university has been really good in that [pause] you know a even if people don't understand they, they know there are things going on and if they do

understand that's great. Clinically, as in on placement it, it's [pause] quite different [laughs].

I: Umm. Did you because we didn't send a letter out for you did we?

P: Yes.

I: We did send a letter out for you?

P: Yes that was quite interesting

I: And and how have you found that affected clinical?

P: Erm [pause] sometimes it wasn't mentioned, on one occasion it was mentioned and [clears throat, pause, laugh] 'don't look any more different or anything to anybody'.

I: Yeah, yeah.

P: Ermm. Which, I suppose I was disappointed in, [pause] because I think, I don't know if you remember, I was kind of a bit apprehensive about you know about disclosing.

I: Umm. Yeah, yeah.

P: Because I know some understand and some don't and not wanting to be, have things made easier or different.

I: Yeah, yeah.

P: Erm. I think it it does boil down to the individual your with erm and their understanding of the implications.

I: Umm.

P: Because if if they can't, or if their not able to understand, you can't expect them to you know appreciate things. Umm [clears throat] I don't know if that's answered your question or.

I: Well I I I just think erm, I I remember you being particularly apprehensive about going to somewhere completely new wasn't it as well, and I think that the letter we sent out was fairly nebulous wasn't it?

P: Yes.

I: It said xxxx will discuss these issues with you when she gets there and I have in the past had a student who didn't disclose anything, and had a bit of an acute episode and went out and said, 'well well I didn't disclose anything because I I didn't want to be framed by "oh this is the student who has mental health issues"'. So we said well okay fair enough but try it my way this time. Erm. We sent a letter and at the end of that placement they came back and said, 'you see I knew that would happen everything I did was oh but, oh but erm and I was, I felt I was, I was the label and then myself afterwards'. So the next time they went out we didn't send a letter erm, and er it's really difficult difficult to advise, and I very much appreciate the reluctance of students with mental wellbeing issues about disclosing. There's that word again. Erm. Because.

P: Because its so difficult to, to actually say anything useful to help either way.

I: Yeah.

P: I think it's a really difficult I think, I I wanted, you know, you to send a letter so that it had been registered.

I: Yeah.

P: So that if anything did happen, you know, no one could turn around and say well you didn't tell us.

I: Yeah.

P: So it was only for that reason, not that I thought there was going to be an incident or anything.

I: Yeah or that you wanted to make excuses or anything.

P: Yeah, yeah. You know it's to be fair to everybody concerned that erm.

I: Umm.

P: You know there may be issues but erm [pause] it's it's a really difficult thing to do.

I: Yeah.

P: And I can't even come up with suggestions on, apart from having some more, erm may be a training or education clinicians on the kind of issues that mental health issues bring, because erm you know education.

I: Is the way forward.

P: Is the way forward.

I: So do, do training but we tend to focus, I must admit, because I do the training, and I tend to focus on the dyslexia, because the the majority of students with any extra support needed erm its dyslexia. However, erm I do mention you know other conditions as well, erm and what I've started doing is getting students in, and that's been interesting and I've had some students in over the last year, I've had students in to help with this training erm and I got some feedback recently, because I'm visiting erm the student, and the clinician said I came to the new educators day and it was really interesting it was really valuable to hear from the students their their experiences with er having disabilities supported, but I wanted to ask a question, but I didn't want to ask it in front the for the students. Erm, and it was a question about how much, erm, leeway in the marking criteria should be given to the student. Erm, I said well were not asking to give leeway marking criteria, it's about supporting them sufficiently so that you can mark them on the same level, may be they won't have such a big case load but they should still be, you know,

P: The same.

I: Working through things, you know, erm but I thought it was interesting that she didn't want to ask that because with the students there. Erm and I don't see why not, but I think its political correctness.

P: Umm.

I: To an extent. I suppose the students could have said it.

P: It is difficult. Yeah I suppose you're kind of prying into peoples.

I: Yeah.

P: Personal space.

I: Yeah.

P: Feelings I don't know. Erm. But I I think it's a really difficult one to.

I: Oh that would be useful if if you could give me give me because at the moment I use the stuff out of the CSP book, with regard to mental health, and I I used to sort of go this is, like your symptoms of students who might be struggling with mental wellbeing, if there's mood swings, umm and being very tired and withdrawn and things, rather than this is how you can help them er so if we could work together on a few pointers then certainly we could do that.

P: Yeah I'll certainly think about it.

I: Yeah.

P: Because I mean I suppose you know that's that's a really good exercise for me to actually, you know, be able to say to people well how will I know if there is a problem.

I: Yeah, yeah.

P: You know and I suppose you, or one erm, develops just your own routine how you deal with stuff.

I: Yeah.

P: You know what things you find difficult.

I: Umm.

P: you don't actually think about it you just kind of.

I: Umm and its really important as well I think to try and er when your supporting someone with a mental health issue, out on clinical and if their struggling on clinical, it's about trying to unpick so is this just because they are struggling on

clinical? Is there something else happening in the background? Have they got their support in place still? Er and short , and the only way can do is actually ask them that's what I've done in the past is say 'okay I know that you know that I know erm that you've got mental health and have had mental health problems are you seeing your CPN? Is everything ok? Do you feel well in yourself?' And only you can answer that, can't you? I can't, I might be looking for non-verbal cues, like eye contact and.

P: Yeah, yeah.

I: And looking tired and things but you know as we've already said the physio degree is a hard degree [laughter]. Everybody looks tired that's not really a very helpful sign, so erm and I think its having the confidence I think, to ask the question of the person erm.

P: Or may be even having erm, I mean I was conscious of of err tutor visits but it was for clinical, and not necessarily from from my.

I: No it's pastoral as well.

P: But I think I, because I was trying to be 'normal' and I suppose I didn't want it to be part of that thing but may be, you know, er er a phone call at home, away from the placement.

I: Yeah, yeah.

P: That's just the way you know I was 'I'm here, I was professional this is what I'm doing'; then at home I was dealing with you know whatever.

I: Yeah, yeah.

P: And...

I: Yeah I've done that and done an email follow up to a student before who who erm yeah 'how is everything?' separate to the visiting....

P: ...Yeah yeah, because you are your working your doing you viva stuff and all the rest of it, so I may be that's one option to actually...

I: Yeah.

P: ...Just say you know on the side. Yeah.

I: And may be actually the other thing we could do is get somebody over from the student disability office, the one of the mental health team, to come and do erm a er talk either to the academic staff and /or, or the clinical team or the clinical educators day about this is how people with mental wellness issues might react er on placement if they're feeling overwhelmed and things: that's an idea.

P: I think, I think, I mean it's difficult for me to be objective when I'm thinking about, you know, the educator experience I had, erm but I feel it would benefit erm: because obviously there looking at your clinical...

I: Umm.

P: ...Performance and, you know, they've got 100 and other things...

I: Umm.

P: ...To do as well so may be just another kind of insight into- Ok, you know the student's doing this, this, and this for this patient, Blah, Blah Blah- Just take ½ hour out and write notes on well what are they actually doing and how are they behaving 'cos things you don't know the student, kind of, outside of that placement..

I: Umm

P: you don't know what their, kind of, behavior is anyway.

I: Yeah. So thinking about erm, to disclose or not to disclose, for want of a different word, what have you been doing with your job applications?

P: I spoke to the careers office about that and, because it says, you know, do you have a disability, and it's sort of 'Oh, Err,' [sounding unsure] and I have put, I've disclosed everything on the application form: for safety and legal reasons and where I've stumbled is the one where it says 'do you want to be interviewed because you have a disability if you meet the criteria?'

I: Ummm

P: And I've put on to that.

I: Right

P: I've only done one application so far [laughs]. ERm, because again I don't want to ...

I: Get that token disabled interview?

P: No, and I'm kind of thinking is it time for me to, to still disclose, because I wouldn't feel comfortable not doing that, because I think it is, I think it's a condition that is ongoing. I don't think, I think things change, but I'm not sure you'll ever be free.

I: Ummm

P: That's just my perception

I: Ummm

P: erm, but I don't want to necessarily go in on that footing.

I: Yeah. Yeah. Err..

P: Maybe that's wise, maybe that's unwise, but that's the path I'm down at the moment [laughs]

I: So you don't want to feel like you've got a job because you played the disabled card?

P: Correct, because I won't, and if I don't get a job because I haven't done that then so be it! At least I'll be happier that I've done it...

I: Ummm

P: ...Like everybody else.

I: Ummm, so it's also about belonging again in a way isn't it?

P: Err, it's, no it's not about belonging it's about being comfortable that I am being err, assessed on my clinical ability.

I: Merit?

P: yeah.

I: Yeah, rather than any disability issue?

P: Yeah, yeah.

I: Ummm.

P: yes (indistinct word) [nervous laugh]

I: we've done the advice for students, err, we've done that one, do you know, are you a member of the CSP?

P: yes.

I: Do you use iCSP very much?

P: A tiny, tiny bit. I do, and I think I get caught up in stuff and I get so interested and I get side tracked and I have to stop. So I can have more time to do that now...

I: ..Now, yeah. Do you know that there's a disability network, a CSP disability network, erm which you can access by the iCSP? ERm do you think that you may look a joining that, or do you feel any need to, or you don't feel a need to?

P: I will have a look and see what kind of things are going on, erm, but as you mentioned before, I do get the feeling that disability is a kind of dyslexia or a non-able bodied and I, I have a huge thing that mental health is still...

I: It's about well...

P: ...in the closet [laughs]

I: yeah, I agree with you, yeah.

P: It's kind of, 'we know it's here, we're not quite sure what to do with it, we know we've got to do something with it' and I've even had lecturers making comments about you know, 'being sent to the funny farm, and...'

I: give me their names and I will...

[laughter]

P: I know I have taken a deep breath, in jest, you know in harmless, and I think when you're not involved in it, it is that funny and they understand the point that they are making, but when you're kind of involved, have been involved, you just think there's this whole load of stuff going on that you don't understand, and also I suppose the danger for me is that you're teaching students the non-holistic path's still...

I: ummm

P... Up and running.

I: the biopsychosocial isn't happening.

P: no and that was, that was quite worrying for me in term of the majority of students that are very developmental age, you know learning from their peers, what's acceptable behaviour and we all go ' oh, you can say that, that's fine'.

I: Yeah, yeah

P: and I'm not saying that people are going to do that, but it's ... yeah.

I: Yeah and it's about, err, it's sad to hear, because it's sad to think that we still haven't got the message across that you're physical health is very much affected by your mental health and vice versa. So being well, it's not just about not having any physical impairment, but it's about being mentally well as well isn't it?

P: so that kind of says to me ... physiotherapy has got some work to do...

I: Umm, wtill.

P:... on that.

I: But society in general has work to do on it...

P: absolutely, absolutely and it's society, you can't expect any little part of that to...

I: Yeah, yeah.

P: Umm, and it's like ... umm, somebody said to me if Richard Bransom was in a wheelchair then things would be very different in the world.

I: Ummm. Well I Read a paper recently, erm, because I ,this this has been developed by Japanese OTs [referring to the KAWA diagram] because Japanese people have a more holisitc view of their life, erm, so I ended up having to, my supervisor was saying 'well you need to look at this idea about East vs. West and where the difference in perception occurs'. And I found an articles by somebody who's a wheelchair user, Japanese, and does a lot of travelling between Japan and America: and he said that you can look at an airport in both countries and that sums up the attitude towards disability. Erm, in an American airport erm, you are helped to erm, transit the normal airport, so they'll be disabled access within the normal airport. Whereas, no actually let me think, you are expected to use the main facilities that everybody else uses, but then there's help with using that. Whereas, in Japan, you're met at the airport and you're transited through the airport, but in a separate area to everybody else , and he said that sort of like sums up the way in which the two cultures perceive disability. Erm, it's about, erm, you know being, in Japan, it's about being thankful for people helping you and in America it's more that it's expected erm that you should have an equal footing, but don't expect any help transiting it, sort of thing. So I thought that was really interesting and I think, erm to a certain extent, you know that's what happens here, doesn't it? So if you look at the student Hub building, and erm [laughs] the access to the disability area is round the corner, it's not through the main doors, it's round the corner, through these great big wacking doors which you, they were having difficulty opening, you know you've got to have a pass to open, you have to wave your pass before you can hit the disabled button, and the stairs outside: I looked at them and I was thinking 'what's wrong with these steps?' and then I suddenly realized that some architect had this wizzy wiz idea that "we'll integrate the ramp into the steps so won't it look splendid!", but it makes the ramp about 4 times as long as it actually needs to be, not to mention it makes the steps a liability, 'cos I remember at graduation last year my parents were over, 'cos my son graduated last year and my mum 'said what on earth's wrong with these steps? They're really dangerous! 'cos there's all these slopes everywhere! [both laughing] I said 'yes, aren't they just!' 'cos you're thinking 'OK

so you've integrated a wheelchair, but what about the poor blind person who's trying to negotiate these steps and they're all different levels and things?'

P: I do wonder, you know what you were saying about psychology and sociology and one of my theories – I put everything down to development of the species, and it is survival of the fittest.

I: I think there is a natural selection, yes.

P: nature is the survival of the fittest, however our moral me that's developed has said 'well actually, we need to do things for these people'. So there's this kind of two path thing going on where we're all kind of running along here quite happily and kind of making some sort of arrangement along the line.

I: And that's possibly why the special school system developed. Also, I mean the disability movement would argue that that's been made worse by the industrial revolution: so up until that point in like erm, when we go back to Serfdom, when the Lord of the Manor and you tilled your, what did you have, your field, you had you strip farming wasn't it? And the village, you swapped things within the village, and the village supported the people who couldn't go out and that. They were given a role within the village to do, but when work became more and more mechanized, then people who couldn't deal with that mechanics no longer had a role, so they fell out of the group. So previously, they were in the group, 'cos they had some sort of role, even if it was just, I dunno looking after the kids while everybody else was out in the field or picking some bits up behind other people, but when it became very industrialized that role vanished and then they dropped out of the group and then were, then became 'disabled'. So there's why they would say it's society that disables people not their impairment, and it's really, probably the evolution of the special schools system and now they're trying to compensate for that by integration into mainstream schools and things. Err, and I can remember working in paediatrics thinking 'well that's right, you know, these children with disabilities they should be in mainstream schools, but I can see 8 kids when they're in a special school, I can see 8 children in a day. They're all going to be in schools dotted around xxx, it's going to take me a week to see that same number of people, so having gone through that system you suddenly think this is going to be a nightmare for use[i.e. the paediatric physiotherapy team] as

opposed to 'this is so right for the children'. But even then, you know, like the student Hub, they're not fully integrated 'cos they can't go in the same door 'cos they've got to go round the corner to the disabled access...

P: and that's kind of maintaining that.

I: Yeah, segregation. Yeah. It's bizarre isn't it? Well I've got through all of my questions, would you like to give me those notes as well and I've got your...

P: there's nothing of narrative 4 'cos I've got nothing to say [both laugh].

I: I've got your personal email haven't I?

P: yes

I: and if, when I'm writing this up, I mean at the moment it's student 1,2,3,and 4. I think it's really quite impersonal so I'm probably going to bash an email round to say think of a name that you want to be called in the study, 'cos I think it's a bit more personal. Erm, would you be happy for me to continue contacting you?

P: Yes, of course.

I: I mean, did you ever try and get onto the webpage?

P: You know I feel so guilty..

I: Don't feel guilty [laughs]

P: I had it on a list. It said Jo Opie – website [laughs].

I: I'm just wondering, 'cos I spoke to a student yesterday, or earlier on this week, I can't remember when now and she said, do you still want us to go onto the website and I said 'well hang fire because I knew it was bad timing, it wasn't very good timing for me to have an operation either, but hey-ho these things happen don't they? Erm, and erm so I know that when I sent out at Easter I thought 'Oh it's a, really bad timing for all students, erm so I'm wondering about seeing if over the summer you might like to go on there, just to get a bit of discussion going between yourselves, a bit like IPLP

P: [laughs]

I: [laughing] if I dare say that!

P: Shall I wait 'till I hear from you?

I: Yeah, yeah. So what I'll do is erm, I'm off on holiday at the beginning of July so I'm hoping to get it all sort of sorted out by then, which is why I'm doing these follow up interviews, because I thought it completes the cycle, but also it gets some of that discussion going anyway. But erm, I mean even, what would be really interesting would be discussion between everybody with all the different impairments about differences in the action between their university experience and their clinical experience and how to move forward, you know, what can we say, as a group, to the CSP and say 'OK these are our experiences, these are the experiences of students' and you're not the only person to say 'well on clinical it's a bit different to.. and I don't know if you read about the student who had an accident in the second year and the response she got? That's student 10. She had an accident which resulted in her being a wheelchair user and she got some really negative responses about getting back onto the course. Have a read through that one – it's a real eye opener.

P: You've only sent me – is it on the website or... you sent me 4.

I: oh did I? It is on the website, yeah. They're all up on the website. Erm, I maybe didn't send you student 1 and 10 because they're both students who withdrew from the course.

P: No you sent 1 because you said that was still important. Her information, she did withdraw but you did send that one.

I: yeah, well student 10, if I didn't send that one, she's had, she had an accident in the beginning of her second year and they said, you know, it's fine, temporarily withdraw for the year and start again next year, but over the course of that year it became apparent that she would not be able to, she would be a, sort of fairly permanent wheelchair erm and then she had quite a bit of difficulty trying to negotiate getting back on the course and in the end they didn't have her back. Erm, so very interesting reading that one is. Erm, you know you have to put it into context, we don't have the university's side of it, erm, but erm certainly she hit the negative, some negative attitudes that I've, I was pleasantly surprise, but amazed

that everybody was saying 'oh it's all been very positive' and I was thinking 'Oh, right, you know, we've gone on' and then when I spoke to her I thought 'no! [laughs] it was as I thought', it's just very well erm, we're very good at talking the talk sometimes. I think we all are though aren't we?

P: I think, I think it may be , it isn't easy and particularly, you know with the 363 - the leadership and management course, and you know some of the stuff is brilliant but it's the reality of actually doing a lot of these things is a lot more difficult, you know, you know what's to be done and what's the best thing to do, but...

I: actually doing it

P: ..getting things in any kind of situation I think is difficult.

I: Oh, look at the time, we've got to go!

Appendix J: Database Search Strategy

#	Query	Limiters/Expanders	Last Run Via	Results
S36	(dis* N3 'physical therapist') AND (S30 and S33)	Limiters - Peer Reviewed Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display
S35	(dis* N3 'physical therapist') AND (S30 and S33)	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display
S34	(dis* N3 'physical therapist') AND (S30 and S33)	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display
S33	dis* N3 'physical therapist'	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display
S32	(disability) AND (S30 and S31)	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display
S31	disability	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display
S30	DE "Physical Therapists" AND DE "Therapeutic Processes" OR DE "Psychotherapeutic	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display

	Processes"				
S29	((S14 and S21)) AND disab*	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display	
S28	S14 AND physical therap* AND disab*	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display	
S27	((S14 and S21)) AND disab*	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - MEDLINE	Display	
S26	S14 AND doctor AND disab*	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display	
S25	S14 AND doctor	Limiters - Peer Reviewed Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display	
S24	S14 AND 'occupational therapist*'	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display	
S23	S14 AND 'disabled nurse'	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display	
S22	(S14 and S21)	Search modes - Find all	Interface - EBSCOhost	Display	

		my search terms	Search Screen - Advanced Search Database - PsycINFO		
S21	nurs*	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - AMED - The Allied and Complementary Medicine Database	Display	
S20	S14 AND medic	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	
S19	S14 AND doctor	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display	
S18	S14 AND 'disabled health professional'	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display	
S17	S14 AND physical therap*	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display	
S16	S14 AND physiotherap*	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - PsycINFO	Display	
S15	S13 and S14	Search modes - Find all	Interface - EBSCOhost	Display	

		my search terms	Search Screen - Advanced Search Database - PsycINFO		
S14	DE "EMPATHY" OR DE "EMPATHY in children"	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	
S13	DE "ALLIED health personnel" OR DE "ACUPUNCTURISTS" OR DE "ARTIFICIAL limb fitters" OR DE "ATHLETIC trainers" OR DE "AUDIOLOGISTS" OR DE "BIOMEDICAL technicians" OR DE "CARDIOVASCULAR technicians" OR DE "COMMUNITY health aides" OR DE "DENTAL auxiliary personnel" OR DE "DIETITIANS" OR DE "DOULAS" OR DE "ELECTROLOGISTS" OR DE "EMERGENCY medical technicians" OR DE "EXERCISE personnel" OR DE "HEALTH counselors" OR DE "HOME health aides" OR DE "HYPNOTHERAPISTS" OR DE "INDUSTRIAL hygienists" OR DE "LACTATION consultants" OR DE	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	

	"MEDICAL assistants" OR DE "MEDICAL laboratory assistants" OR DE "MEDICAL record personnel" OR DE "MEDICAL secretaries" OR DE "NURSES' aides" OR DE "NURSING home administrators" OR DE "OCCUPATIONAL therapists" OR DE "OCCUPATIONAL therapy assistants" OR DE "OPHTHALMIC assistants" OR DE "OPTICIANS" OR DE "OPTOMETRIC assistants" OR DE "ORIENTATION & mobility instructors" OR DE "PHYSICAL therapists" OR DE "PHYSICAL therapy assistants" OR DE "PHYSICIANS' assistants" OR DE "PODIATRIC assistants" OR DE "RECREATIONAL therapists" OR DE "RESPIRATORY therapists" OR DE "SPEECH therapists" OR DE "ALLIED health personnel & patient"				
S12	S2 AND 'occupational therapist*'	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search	Display	

			Database - Academic Search Complete		
S11	S2 AND 'disabled nurse'	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	
S10	(S2 and S9)	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	
S9	nurs*	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	
S8	S2 AND medic	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	
S7	S2 AND doctor	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	
S6	S2 AND 'disabled health professional'	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search	Display	

			Complete		
S5	S2 AND physical therap*	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	
S4	S2 AND physiotherap*	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	
S3	S1 and S2	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	
S2	DE "EMPATHY" OR DE "EMPATHY in children"	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	
S1	DE "ALLIED health personnel" OR DE "ACUPUNCTURISTS" OR DE "ARTIFICIAL limb fitters" OR DE "ATHLETIC trainers" OR DE "AUDIOLOGISTS" OR DE "BIOMEDICAL technicians" OR DE "CARDIOVASCULAR technicians" OR DE "COMMUNITY health	Search modes - Find all my search terms	Interface - EBSCOhost Search Screen - Advanced Search Database - Academic Search Complete	Display	

aides" OR DE "DENTAL auxiliary personnel" OR DE "DIETITIANS" OR DE "DOULAS" OR DE "ELECTROLOGISTS" OR DE "EMERGENCY medical technicians" OR DE "EXERCISE personnel" OR DE "HEALTH counselors" OR DE "HOME health aides" OR DE "HYPNOTHERAPISTS" OR DE "INDUSTRIAL hygienists" OR DE "LACTATION consultants" OR DE "MEDICAL assistants" OR DE "MEDICAL laboratory assistants" OR DE "MEDICAL record personnel" OR DE "MEDICAL secretaries" OR DE "NURSES' aides" OR DE "NURSING home administrators" OR DE "OCCUPATIONAL therapists" OR DE "OCCUPATIONAL therapy assistants" OR DE "OPHTHALMIC assistants" OR DE "OPTICIANS" OR DE "OPTOMETRIC assistants" OR DE "ORIENTATION & mobility instructors" OR DE "PHYSICAL therapists" OR DE				
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	"PHYSICAL therapy assistants" OR DE "PHYSICIANS' assistants" OR DE "PODIATRIC assistants" OR DE "RECREATIONAL therapists" OR DE "RESPIRATORY therapists" OR DE "SPEECH therapists" OR DE "ALLIED health personnel & patient"				
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Appendix K: Quality Appraisal of Articles in Stage One Empathy Meta-Synthesis

Quantitative Papers appraised with the CASP Cohort Studies criteria							
Author	Aim?	Design?	Recruitment?	Method Bias?	Outcome bias?	Variables?	Follow up
Leierer 1996	to examine the effect of counsellor disability status, counsellor attending behaviour, and problem relevance on the counsellor perceptions of individuals with disabilities.	yes	48 participants, 27 men and 21 women, recruited by a flyer distributed through the offices of students with disabilities at five large state universities. All completed consent forms.	scripts for interactions developed through reviewed stages. Vignettes filmed with same actors playing each role.	counsellor rating form-short	minimised variables as much as possible	n/a
O'Hare & Thomson 1991	aim not clearly stated	Likert questionn aire	23 subjects. Letters in physio & therapy weekly	Likert and some open questions	some negatively phrased questions to avoid response bias	unknown	n/a
Roush 1995	yes: satisfaction of people with MS of OT & PT	not really.	81 participants. personal letter or via an advert in an MS newsletter. Informed consent and university ethics approval	half items scored negatively to avoid response bias. ?validity & reliability.	75% female respondents female. 79% therapists commented on female & 81% therapists=pt	not controlled	mean satisfaction score= 64.1 (total possible=70) s.d. 6.5
Author	Results		Reliable?	Generalisable?		Fit?	Quality?
Leierer 1996	ANOVA completed. No differences for presentation. MANOVA test of other variables. Counsellors with disabilities seen as slightly more attractive, expert & trustworthy. However, attending behaviours were more positively rated in both dis & non-dis counsel.		linked to previous literature	authors discuss limited generalisability of experimental procedures to real-life situations.		supports some studies and refutes others. All discussed by authors	High: and very pertinent to review.
O'Hare & Thomson 1991	descriptive statistics mainly.		no quotes also claims that there were open questions	limited		contradicts some other evidence e.g. French	low: no mention of ethics or reliability & validity of questionnaire.
Roush 1995	Respondents seem highly satisfied with their therapists. Four highest scored items related to communication & rapport. 4 lowest related to treatment, but had highest SD.		questionable as tool not designed for therapists. Also don't really tell much	not really only to MS patient who have a minimum of 4 contacts with		no other evidence similar to this.	low: inappropriate research design.

Qualitative Studies Appraised using the CASP Qualitative research Framework										
Author	Aims?	Design?	Recruitment ?	Data collection?	Researcher influence?	Ethics?	Rigour?	Findings	Value?	Quality level
French 1988	yes: to describe the experience of disabled HCP	Not stated	25 participants: selection discussed.	semi-structured interviews. Tape recorded & transcribed.	researcher's disclosed own visual impairment. No discussion of bias.	Not stated	Not stated	transcripts categorised by researcher into 4 themes: approp. To quotes	links findings to other literature and highlights areas for further research.	Low: this study, gives an overview of the experiences of disabled HPs
Velde 2000	yes: to describe the experiences of disabled OTs	Phen. approach	purposive sampling: 10 participants	open ended interviews: Broad initial Question: describe the experience of practising OT with a disability. Interviews continued until saturation	discussed in limitations	not stated	member checking of transcripts & theme generation. Interpretations reviewed by second party.	3 main themes: I'm sensitive to their needs; the issue is how to cope with life; recognise your own strengths and limits. Rich description with lots of quotes.	links to previous research & implications for practice, research & education.	High, except for a lack of discussion about ethics.
French 1995	not really: cites being part of a PhD	Not stated	24 participants all physiotherapists with visual impairments. Means of selection not discussed.	semistructured interviews: 1 hour long	discussed own visual impairment and that she had a personal relationship with some of the participants.	No mention	no mention	some inclusion of participant comments, but limited.	mainly a discussion of the historical context of the inclusion of people with a visual impairment into physiotherapy	Low: this is an old article, which may have a bearing on the rigour. Also it is questionable whether it was intended to be viewed purely as scholarly article.
Fox et al 2009	yes: 3 aims, build on previous findings, address the gap of experience of illness by GPs and provide information for medical educators	Interp. Phen. analysis. Research team.	Purposive. Any length of service. Significant illness to include any physical, mental, acute or chronic condition. Emailed 2 PCT 17gps contacted researcher	Semi-structured interviews. Participants chose location of interview. 45-90 mins. Single interviewer. 3 broad areas: about being a patient? Has your experience affected you practice? or the way you consult Drs?	participants given info on researcher prior to interview. Interpretive nature of design acknowledged	info sheet including anonymity. Repeated at start of interview. Self selection - implied consent?	interviews transcribed & member checking occurred. Summary of findings distributed to all participants. 1 transcript coded by 2 people. No differences found.	Nvivo used for data management. Quotes included. Team discussed findings. linked to aims. 3 themes: experience as patient; developing empathy; practicing empowerment.	findings linked to prior research by Klitzman(2006). Further research highlighted. Limitations discussed.	High: except for lacking explicit mention of consent.

Oliver 1995	yes: do disabled people need counselling in a way that is different to any other group of people?	explorative qualitative. Grounded theory.	8 counsellors. 3 disabled. 5 non-disabled. Opportunity sample. Telephoning disability organisations, resource centres & word of mouth.	participants given interview schedule prior to interviews. Tape recorded & transcribed.	positioning discussed: nondisabled doing disability research.	not stated	extensive description of grounded theory coding.	& open coding themes and 3 axial coding themes discussed & illustrated with quotes.	linked to future training of counsellors and theoretical discussion. Little linking to literature. highlights lack of disabled voice from people being counselled	Low: only one category appropriate for this review.
Klitzman 2006	not explicit. Systematic research required to explore physicians' disclosure of illness	grounded theory. PI & research assistant	recruitment through email, websites, newsletters or word of mouth. Pi contacted by 48 Drs/ dentist.	2x 2hr semi-structured interviews. No indication of topics. Participant chose location. Audiotaped.	no mention	ethical approval from university.	transcriptions examined by 2 people to develop themes.	developed model for dr-patient interaction. Included quotes from participants: themes- patients decisions about asking; drs decisions about disclosure; effects on relationship.	linked to literature. involved will enhance patient-Dr interactions.	Medium: lacking in explicit discussion of ethics or researcher influence.
Beech 2004	yes: to inform controversy about boundaries of disclosure	qualitative analysis of previous research data (1993)	125 Dr participants. Patients selected from Dr's waiting room. 1265 patients included. Drs selected from databases of insurance companies. Eligibility criteria discussed. 81% agreed to be included.	1265 patient visits audio recorded. Coded using RIAS. Distinguished social chat from medical relevant disclosure.	no mention	Original research had hospital ethical approval. Informed consent gained from Drs and written consent from patients.	Inter-coder reliability calculated across 121 tapes. Categorised disclosure units by 2 researchers.	1 self disclosure / 15.4% visits. Median no. of disclosures per physician =2. Majority of disclosures were spontaneous. Themes: reassurance; counselling; rapport; casual; intimate & narrative. Participant quotes included.	linked to previous literature. Discussion of limitations & area for future research.	High, but not all relevant to review.

Shattell et al 2006	yes: examined mentally ill patients' experiences of what it is like to be understood.	existential phenomenological approach	purposive sampling: MH clients experiencing being understood. Recruited through newspaper. 20 people volunteered.	interviews. describe an experience when they felt truly understood by a health care professional. Audiotaped. Read & analysed	Not stated	university approval. Written informed consent	thematic framework presented to research group & 3 participants	context theme: misunderstanding. Other themes: I was important; it really made us connect. The got on my level	linked to literature. Practice implications. No mention of limitations or generalisability	medium: limited participant voice, pertinent to research
Johnson 1993	yes: to explore experience of physiotherapy of disabled people and the attitudes of therapists	not stated	purposive sample recruited from centre for integrated living. 4 participants agreed. 2 men 2 women	semi-structured interviews	student physio so felt that people would be more able to discuss negative opinions. Also commented on nondisabled interviewer and willingness of disabled people to disclose.	information sheet and confidentiality declared.	interview guide published.	3 broad themes: level of independence, experiences of physio, role of physio with disabled people. extensive quotes from each person	linked to literature. Limitations discussed. Implications for clinical practice and further research	high & very pertinent to review hence inclusion although 1993
Darragh Sample & Kreiger 2001	yes: expectations of health professionals	Phenom. Part of larger study. This section focussed on practitioner qualities	opportunistic sampling from local brain injury support groups. 51 participants 24 men 27 women	interviews. Audiotaped. Conversational style. Transcribed and analysed	discusses research reflexivity	not mentioned	Triangulation of data. Set order for interviews. 2 researchers analysing transcripts.	3 major themes: role of provider; helpfulness of provider; personal characteristics of provider. Lots of participant quotes.	linked to literature. Practice implications discussed.	high & pertinent to review

Systematic Review Appraised using the CASP systematic review tool									
Author	aim?	included studies?	search acceptable?	quality assessment?	reasonable to combine results?	findings	generalisability	implications for practice	quality rating
Whalley Hammell 2007	yes	appropriate	wide searching of databases, reference lists and hand searching of appropriate articles	yes. Only included papers with strong participant voice	yes and exact process highlighted	identified 7 concepts across the papers included: staff qualities; need for a future; importance of peers; institutional rehab; need of real world; content of rehab; connecting past & future; hope	total participants over 8 papers =125. author discussed limited generalisability to English /western cultures	wide implications for rehab services	High: appropriate to review question

Appendix L: Letter to the CSP / HCPC requesting access to interview staff

Dr H Johnson,
Chartered Society of Physiotherapy,
14 Bedford Row,
London.
WC1R 4ED.

27 Cromarty Drive,
Hinckley,
Lecis.
LE10 0RX.

j.opie@coventry.ac.uk

Dear Dr Johnson,

9th January 2013.

We met briefly at the European Education Conference in Vienna in November, which I attended to present a paper on my PhD research (copy of the slides included). I am writing to you to seek permission to contact members of the CSP administration and the disability network to collect further data for my PhD project. I will not approach anyone until I receive your permission.

The topic of my research is about the experiences of disabled physiotherapy students and the accessibility of physiotherapy as a career for people with disabilities. Up until now my data collection has been focussing on the experiences of the physiotherapy students who volunteered to participate. I am now moving into the second stage of my research which is looking at this issue from the perspective of the professional bodies, such as the CSP. To this end I am hoping to interview representatives from the CSP in order to collect data about the profession's current policies towards recruitment and support for students and physiotherapists with disabilities. I enclose a copy of my participant information sheet and consent form and can assure you that I have been granted ethical clearance by Coventry University where I am studying for my PhD.

After my presentation at Vienna I was approached by Nina Paterson who expressed an interest in discussing some of the information highlighted by the student participants, but I asked her to wait until I had got my ethical clearance to approach the CSP and gained your permission to contact her. I am also a link member of the disability network and would like to contact Cliff Towson and Mike Cassidy who are the convenors of the disability network.

Could I please ask you to inform me of your decision, via email (j.opie@coventry.ac.uk), before the end of January? If you think there are any other people who would be relevant to talk to I would be grateful if you could forward their names to me.

Thank you for considering this request,

Yours Sincerely,

Joanne Opie MSc, BSc, MCSP.

Dr van der Gaag,
Health and Care Professions Council,
Park House,
184 Kennington Park Road,
London.
SE11 4BU.

27 Cromarty Drive,
Hinckley,
Lecis.
LE10 0RX.

j.opie@coventry.ac.uk

9th January 2013.

Dear Dr van der Gaag,

I am writing to you to seek permission to contact members of the HCPC Council to collect data for my PhD project. I will not approach anyone until I receive your permission.

The topic of my research is about the experiences of disabled physiotherapy students and the accessibility of physiotherapy as a career for people with disabilities. Up until now my data collection has been focussing on the experiences of the physiotherapy students who volunteered to participate. I am now moving into the second stage of my research which is looking at this issue from the perspective of the professional bodies, such as the HCPC. To this end I am hoping to interview representatives from the HCPC in order to collect data about the current policies towards registration for students and physiotherapists with disabilities. I enclose a copy of my participant information sheet and consent form and can assure you that I have been granted ethical clearance by Coventry University where I am studying for my PhD.

Could I please ask you to inform me of your decision, via email (j.opie@coventry.ac.uk), before the end of January and indicate which council members you consider would be most relevant to contact?

Thank you for considering this request,

Yours Sincerely,

Joanne Opie MSc, BSc, MCSP.

Appendix M: Exploring the Accessibility of the Physiotherapy Profession for Disabled People

1. The CSP and HCPC have both produced information about recruiting disabled people into physiotherapy. Do you feel these documents are sufficiently accessible for a prospective disabled applicant?
2. Does the CSP/HCPC keep any statistics about the number of disabled physiotherapists currently registered in the UK?
3. Do these statistics make any record of specific impairments?
4. It is estimated that disabled people make up 10% of the population of working age. Do you think this is representative of the percentage of disabled people within the profession?
5. Are you aware of any physiotherapists who are wheelchair users and are working as a physiotherapist? Did they complete their training as a wheelchair user or did they acquire their impairments post qualification?
6. Do you think a disabled person has any specific qualities that would benefit their practice as a physiotherapist and the profession in general?
7. Do you think we could do more, as a profession, to enable more people with impairments to consider physiotherapy as a profession?
8. How much involvement does the disabled members' network have in formulating the policy and the practices of the CSP?

Appendix N: Transcript of interview with HCPC representative #1 and CSP representative #2

HCPC Representative #1

P: HCPC, xxxxx speaking

Hello xxxxx this is Joanne Opie here.

P: Hi Joanne how are you?

I'm fine how are you?

P: I'm good thanks.

I'm just playing with little bits of equipment, to make sure that I've got the recording working and backing up as well, so erm.. it's all good fun, technology's wonderful isn't it?

P: Hmmm.

Providing it works OK [laughing]. Right I've got 2 recorders going now. Is it OK if I record the conversation?

P: Absolutely.

Oh brilliant. Erm now, did, I sent you a copy of the questions didn't I?

P: You did yes.

Right OK. Erm so, shall I just tell you a little bit about the background of my research to start off with?

P: Yeah that would be great.

Interestingly I've just been forwarded your invitation for research proposals on erm guidance for disabled people,

P: Oh that's good

erm and I'm thinking 'Oh look that's my PhD [laughs], but I've just been looking specifically at the moment at erm physiotherapy so I've already done erm a chunk of it, so erm, you might be seeing an application – well actually I'd like to have a chat with you about that towards the end erm of the interview if that's OK?

P: Yeah, no, of course, no I'm pleased that erm it's already been kind of circulating around, which is good.

Yes it is isn't it, yeh.

P: I only actually sent it out to various contacts last night actually. So everyone's very quick off the mark.

Yeah, yeah, well it's my, er the, I work really closely with our student disability office er and so it must have bounced into their inbox and er got bounced straight across to me so er I've got them well trained to pick things up.

Erm, so my research is looking at erm I suppose my background as a physio is working er with children with disabilities and then when I went into erm the university, erm because of that background they said 'oo, you could look after all the students with disabilities then'. Erm, and so I, er, got that role. I now support the whole faculty (the faculty of health and life sciences) in making sure that we put all the, er, reasonable adjustments into place within the erm different departments in the faculty and liaise really closely with the student disabilities office. Erm and really on a basis of that, erm, my interest in supporting students with a disability has grown and grown and hence this has become the topic for my PhD studies.

P: Yes

Erm, I started off from the perspective of students erm, 10 student participants, who we've done sort of like a bit of longitudinal research with: looking at their experience of the admissions process, and the course, both in university and out on clinical placement and then the transition into erm er qualified life. Er so they've helped me with that and now I'm onto the erm, looking at all the surrounding areas: so the documentation and the policies within the HCPC and also the CSP and the QAA erm benchmarks and things like that to build up a really complete picture of erm the support that there is for students and to see the areas of good practice and to see areas where actually we think we're doing it, but maybe we're not doing it as well as we think we're doing it. Erm, so that's what led me to then contacting the HCPC. Erm, and yourself and xxxx. Erm and a lot of the questions on the list have, are, have come to me from either things that students have said and also sort of my research up until this point, you know literature searching up until this point.

P: Yeah

Ok

P: Yes that's, absolutely fine.

Erm, so shall we, I'll just sort of go through the questions. I've got a few extra ones as well as I've been reading through documentation er, but I'll get to those at the end. Erm so question 1: erm 'do you think the documents, erm so the erm guidance for students applying that the HCPC erm developed, do you think that they're accessible to the target audience?

P: Erm, I think probably now that time's gone on, no. So I suppose you've seen from the brief...

Yeah

P: ...that for us that the guidance we produced I think was quite well received, I mean I was certainly involved towards the tail end of its development erm at the time and published in 2006 as the disabled person's guide erm I think. I mean, I think. I mean a couple of things for me in terms of accessibility: I think one would be that when we redraft it next time I think we just want to try and be a, I think it was quite plain English and quite clear...

Hmmm.

P:...and it had been crystal marked by the plain English campaign, erm, but I do think that next time round in revising it we probably just need to think a bit more about the needs of the audience which is why we want to do the research we're commissioning with disabled students, 'cos as, kind of being the main users of the guidance erm, whereas last time round when it was developed it was developed by a working group, I mean that included people that were. You know, really experts in this area like xxxxx,

Yeah,

P: From xxx, but it didn't include directly disabled students, who obviously are the people who've kind of been there and thinking about whether they want to apply and kind of uncertainties and any anxieties that might have about that and are kind of in the best position to kind of inform us about how accessible it is. Erm, I certainly think there's some parts of the guidance that are perhaps not erm as realistic or as real world as they could be..

Hmmm

P: So the guidance has got quite a few examples of kind of decisions that people might make and I'm not sure how real world they are. One or two of them, particularly in the education providers section are perhaps a little bit unrealistic...

Hmmm

P: ...And don't actually reflect that kind of reasonable adjustment decisions that education providers make. Erm, so I suppose that's why we're reviewing it. So I want a real focus on actually kind of how accessible is it to disabled applicants erm and and related to that I suppose is dissemination: so I think you always have a lot of kind of energy and kind of erm hard work in putting together a document and engaging with people and consulting on it and revising it and getting it out, but I don't think last time round we did anywhere near enough communications activity...

No.

P: ..so actually disabled people, not only when they're on a programme and maybe they've got a kind of concern about what, how that links with registrations. 'cos we often find that actually people who are on the programmes will contact us sometimes as well.

Hmm.

P: And it's been useful to refer them to that guidance document. Erm, but actually how do, you know, has the document ever actually been used by a disabled application what ever age they are who is contemplating applying to a physiotherapy programme?

Yeah

P: And I suppose we don't know, erm, and I think next time round I think it's that kind of dissemination strategy that's important.

Yeah.

P: How you kind of tackle it at source I suppose rather than later.

Yeah, I mean, certainly, that I've currently got a questionnaire out to careers advisers in our local area. Erm, to see if they've ever heard of it .Erm, along with the CSP document . Erm, you know, asking them what would they do if a student with different impairments came and said I want to be a physio? So it will be interesting to see, erm, in the responses of that, erm, whether it is, you know, sort of hitting the target audience.

P: Absolutely, yes.

I think, I mean my, I did a little search on the HCPC website and I've done the same thing on the CSP website to try and find, and I did a search with 'disabled applicant' and it came up with 13 items and the guide was 13th on that list. If you do a 'disabled student' search you get 100 hits on the HCPC website and er the document's 65th in that list so it's, I think we put things up on websites and I know our university is a bit the same, erm, and you think it's up there so it's accessible, but it's not always that accessible as you think it is.

P: No, I agree and to be honest the search function on our website is not very good [laughs] and err, one of the projects we're looking at at the moment is actually completely overhauling the website.

Yes.

P: I think that's one of the areas that doesn't work for me. You know, as a staff member trying to find something every now and again.

Yeah. Well we've just erm, tackled that with our university website and had a link on the first page: 'information for disabled students' and then they've go and revamped and we've got a new website and goodness knows where that link's gone now. So that's something we've got to do from our end, erm, with the website builders. Em, do you actually, I've been looking through your disability equality ,erm, scheme and all the documents, and I see that you keep registrants' information, sort of gender, age and things: do you actually have any, er, statistics on how many disabled physios there are currently registered?

P: Er, we so in terms of our role we're, erm, you'll have to forgive me as I know some of the terminology has changed for the Equality Act 2010

OK

P: And I was very au fait with they way it was worded previously [laughs].

Yeah [laughs].

P: Erm, the er, as an organisation we have to meet the general duties around kind of equality I think ensuring, erm, equality of opportunity

Yep

P: But unlike one or two of the other regulators, like for some reason the chiropractors, um regulator and the doctors' regulatory, we aren't legally compelled to publish, to actually produce, erm, as scheme.

Yes I realise that.

P: Because of that the advice we previously received was that we were limited around the, actually having a just cause if you like ..

To collect it, right.

P: ...To take this information from people. Particularly in a way that would actually make it meaningful, so I think that's always the challenge isn't it?

Yeah.

P: So you can collect the data, but actually is it worth, is it proportionally worth the effort and what you going to do with it? How will it actually help you know whether your process is free of discrimination, or whether it's enhancing equality of opportunity? Erm, so to cut a long story short, we do collect some data, so applicants to registration; part of the application pack is an equality and diversity form that people are asked to complete on an anonymous basis where one of the questions is 'do you perceive yourself to have a disability?' Erm, we've had that running for a number of years now and we've yet, we need to really review about whether it's necessary to keep on doing it.

Yeah.

P: So I would be able to report on how many people who've completed the form said that they had a disability.

Hmmm

P: And by profession as well, but it may be a very incomplete picture, 'cos it would only be those UK and international applicants over the last 3 or 4 years who have decided to fill in the form.

Yeah

P: And 'cos not everyone does.

No because some people don't perceive themselves to have a disability. Erm..

P: Actually they may well say no when other people would objectively think they did or they may just not fill in the form.

Yep, yeah. So it is, it's that grey area isn't it and as you say, what do numbers mean anyway.

P: Yes, absolutely. Erm, and that was, the form is a simple 'do you consider yourself to have a disability?' yes or no rather than a free text fill to say what kind of disability.

Yeah, yeah. So, erm, looking at question 4: this is like erm, something that's looked at at HE in general: that disabled people estimated make up 10% of the general population, but they don't make up 10% of the general student population. Erm, sort of, do you think we're getting in a way near that with regards to erm health professions? Anywhere near the sort of like 10% mark?

P: Yeah, I mean I suppose because we don't have data I wouldn't be in a massively informed position to answer the question.

No.

P: Having said that you know I suppose I've always been aware and I've been at HPC, as it then was, for over 8 years myself. Erm, I've always been aware, when I've been working with issues that actually the tradition in physiotherapy, there has been a particular tradition in physiotherapy around people with disabilities particularly people with visual impairments going into physiotherapy.

Yeah.

P: So certainly, certainly kind of the efforts the physiotherapy profession makes are often a bit more visible to me than they are in perhaps other professions. So

maybe that's a good indication that at very least there's been effort even if it hasn't led to 10%.

Yeah, well it's helpful with Karen and Jane down at UEL as well isn't it? And their specific unit, which as you say, is historically linked to the RNIB and erm people with a visual impairment being advised to have a go at physio. Erm, are you aware of any people erm within physiotherapy who are wheelchair users?

P: Erm, I'm, no I'm not. I am on the visual impairment side. One of our council members had a visual impairment.

Yeah.

P: But no, not on the wheelchair side.

Yes. I mean that seems to be the one disability that we may be out there and encouraging people er with different disabilities to apply, but the wheelchair becomes I think our stumbling block. Erm, the ability to work, to see outside the box, really to see outside the non-disabled box to see if, if somebody who is a wheelchair user on a fairly permanent scale would be able to train as a physio student. I know there have been people who have become wheelchair users as an acquired injury post qualification, but I haven't heard erm of anybody who's gone through the training as a err, fairly fulltime wheelchair user. I know there's people who have and haven't used wheelchairs.

P: Ummm

Do you think that a disabled person brings any qualities that a non-disabled person doesn't to the therapeutic relationship?

P: Well, I mean, I'd say that, I suppose you wouldn't ever want to, I suppose in answering that question I suppose you wouldn't want to get to the situation where it's almost if you have a disability you're at an advantage to someone who's able bodied who doesn't also have kind of qualities that they can bring as well. Erm, and I suppose the best analogy I kind of was just thinking about on this one is that I suppose in some of the kind of psychotherapy professions erm often it's talked about that actually having prior contact with therapy yourself at some point before the commencement of training erm is often what they look like in terms of someone having a realistic appreciation of what the profession's about, but also having kind of insight and self-awareness. Erm, and I wonder whether there is kind of an argument at least, I don't know what kind of disabled physiotherapists would think of this, of saying that er actually although again it shouldn't be a barrier for someone who's able bodied to going into the profession, of course, actually a disabled person going into the profession as a physiotherapist at the very least kind of has a, perhaps a little bit, has kind of value that they can contribute in terms of experience of actually having a disability and having interaction with other

groups of erm health and care professionals erm and actually kind of insight into kind of the other side of the equation if you like, not just what it's like to be a professional but actually what it's like to be a service user in direct receipt of services.

Yeah, having gone through the experience themselves. Yeah.

P: And I suppose the other one is really that this erm you know I don't know how much this is the case but it's kind of I suppose a lot of the kind of all the initiatives around kind of disability are always around kind of challenging preconceptions and stereotypes..

Hmm.

P: And I suppose the argument's the best way of doing that is by actually having people within the profession who immediately challenge those preconceptions and stereotypes..[laughter]

Yeah.

P: As they're doing it.

Yeah. So that acting as trailblazers really?

P: Yeah.

Yeah, yeah. Do you think we could do, I mean you've already said that you think that the err, CSP and the physiotherapy profession do quite a lot. Do you think there's anything, do you think we could do more as a profession to, erm, enable people with impairments to consider physiotherapy as a profession?

P: Yeah. I mean, I suppose, one reflection I would have is that this is very anecdotal is that, And I don't know whether this is a good reflection, just generally overall across the AHPs and other professions that we regulate: erm, we used to get a fairly steady stream of enquiries from err, you know individuals, practice educators, admissions staff and also disabled people asking questions about you know can I really give an offer to someone, a place on this course because of x impairment.

Hmm.

P: We got I suppose a steady stream of them and that was why the guidance was produced originally, err in 2005/6 and I remember the first few years after that we still were getting those kind of enquiries, and we don't now. Erm, and I you know, I suppose it's a bit hard to know and the research will help us on that. And I, I just wonder whether that's kind of an indication that perhaps erm at the very least some of the basics around thinking err pragmatically and kind of holistically about

whether you are able to support someone who has a physical or some kind of impairment on a programme that perhaps kind of those, that's kind of become engrained in kind of normal practice rather than something that's novel and people think they need to seek guidance on the regulator for. Erm, it's quite rare that we answer those kind of enquiries now and they would come to my team erm you know occasionally we might get something from a student who's kind of worried about what, whether they'll get registered at the end because they may have some kind of impairment and they want that reassurance, but we're certainly not getting it from the other side from the professional audiences.

Yeah.

P: So I think that's kind of one kind of an indication that you know that kind of basic hurdle of getting over preconceptions and kind of those kind of err barriers because of people's unwillingness to kind of think laterally has gone maybe?

Hmmm

P: Erm, I suppose, there's probably a lot more that we could do. Erm, I suppose when I think about the guidance I think that one of those things is actually around dissemination. Erm, I can't imagine, you know there's erm comprehensive erm guidance that the CSP have produced and the one that we have produced previously, I can't imagine that a lot of people are aware of it. I'd be interested to know the outcome of that part of your research [laughter].

Yeah [laughter]

P: I think that's part of it you know you can go along way in producing guidance but if people don't know about it it's not going to get people to think at a much earlier stage whether they want to consider physiotherapy as a profession. Er and I think that's a hard thing because it's catching people as you said in careers services. Possibly when they're in er in their teens still before they start thinking about disregarding certain subjects at A level when all those other kinds of decision points.

Yeah. You see you've actually got to get them before they're 13 really.

P: Yes. Absolutely.

Potentially in their options for their GCSEs or whatever they're going to be in the future[laughs]. Erm, yes it's getting that information out erm and I think it's all very read- write information at the moment isn't it? Erm you know some little video clips and film clips and case studies with students talking about their experiences I think would be valuable as well.

P: Yeah. I do agree. Yeah, absolutely.

Yeah. Erm, having looked at erm the SoPs and SETs and etc over the last few days erm, because we're going through our revalidation process at the moment, at university, er so SoP and Sets are very high on the agenda at the moment: erm I see that you, in days of yore we had to get a health declaration form didn't we to register..

P: Yes you did, yes

... but now that's gone by the by. It's just this statement about being of good physical and mental health.

P: Yeah, or you aware why that was changed? I can run you through that if that helps?

I think wasn't it because Drs didn't really know what they were doing with the form?

P: Yeah. There were a few things. So erm, again I used to answer questions from Drs who sued to sometimes complain and get really really shirty and refuse to sign people's form 'cos they would say 'well I don't know what the requirements are in physiotherapy or in orthotics!' and I think that was the issue. We were very clear in separate guidance we produced that you won't find because it's defunct now, that actually they weren't being asked to say, erm, they were being asked to judge kind of insight and awareness erm and even if they signed they could provide more information if they wanted and they kind of felt that they were making some kind of occupational health assessment on whether someone should do it [laughs] and it kind of added the, it kind of ended up being an inadvertent barrier to some people err who erm, it was just a bit unfair. I mean the other context was that the enquiry from the disabled, erm disability rights commission into fitness standards in regulation which said that actually the very fact that you have a health reference dissuades some people from even contemplating it later on. Erm, and we did find that, again I kind of worked years ago on that from this side of things as well. We did find a lot of the time you know the information that was included in the form which was in addition we'd consider it and we'd go to a registration panel, but actually there was nothing wrong with that, it was you know it, I suppose the issues is that just because you've got some kind of condition who ever you are doesn't mean any thing at all, it's about how you manage it.

Exactly, yeah.

P: And that's kind of the main focus of our standards. So that's why we've gone to a self declaration. Erm, I mean some people criticise that because they say well how is that going to pick up someone who's not got insight and understanding?

Hmmm

P: Erm, but I think it kind of has to be some kind of appropriateness really, erm I mean the kind of cases we tend to deal with when they're health related it's about registrants aren't cases which are you know you've got an alcohol condition therefore we're going to get you off the register, they're always about the fact that the health condition hasn't been managed properly, there's a lack of insight, there's a lack of self awareness and therefore it raises the issue of harm, it's caused harm or it raises the risk of harm to them or to other people.

Yeah.

P: Erm, so kind of having a health reference was a bit inconsistent with kind of common sense.

Yeah. So do you think, erm, 'cos picking up when you mentioned the disability rights commission, erm, they did that big legal erm report back in 2006/7. And one of the things identified there was about standards relating to health: that, erm ,they actually question the validity of them at all. Err, and suggesting that standards should be related to the ability to practice competently and safely and if it was couched in those terms you wouldn't need any sort of health declaration, because that would be covered by this ability to practice competently and safely. Erm, what so you think about that?

P: Erm, I suppose, possibly it's kind of an incremental approach, maybe in a few years we might think to ourselves, 'well actually do we need that declaration?' or could it, should the declaration be changed? Should it be I understand the importance of maintaining my own health or something like that, I don't know. I certainly think for us the reason why we, we got rid of the health reference, which I thought was really good and ahead of a lot of other organisations, 'cos we simply just thought it wasn't working for us for a start [laughs] erm I think the difficulty is that when you think about, when we talk about fitness to practise we always mention health, 'cos health is always some think that can impair your fitness to practise. That doesn't mean that we should be discriminatory, erm, I mean the main area interestingly where we have a standard on health is in the standard of conduct, performance and ethics. Where it says you should stop practising or change your practice if your judgement may be impaired because of your health. Erm, and kind of we see that as quite an important standard which gets referred to quite a lot really when we tend to answer enquiries from people. Erm, really interestingly we started to review that set of standards and we had a couple of people well a couple of different audiences so a registrant audience and a service user audience both questioned why that standard's there at all. Erm, and whether we should change it and erm whether you know it been suggested that it would be employers responsibility to make sure those issues are covered off. Whereas from our perspective there's still some kind of individual responsibility whether you're disabled at the point of entry to the register or healthy at the point of entry to the

register to make sure you always manage your fitness to practise, which includes your health.

Hmmm.

P: The only other area that sets standards is that I think we might about getting rid of in the future is there's something about umm infection...

Yeah

P: ...In the standards of conduct, performance and ethics, which when you read it really the original, the origins of that again are a little bit before my time, would have been in kind of anxiety around..

HIV

P: ... HIV and communicable diseases. Possibly the kind of world's moved on a bit, to actually be mentioning that given that you know slowly but surely people have got away from kind of bans of people in certain professions who've got those kind of conditions and doing certain things and gone to something that's much more about mitigating risk and being reasonable and pragmatic.

*Hmmm. Yeah. Erm, with regard to umm, going to the standards of proficiency specifically for physio now; erm, I mean I like the fact that we have in the HCPC erm that fact that you've got to meet standards, but how you meet them isn't judged it's that you just meet the standards. Erm, but a lot of the standards, I've been sort of really picking up on the language used: that are linked to being able to **use** [emphasised] appropriate techniques or erm assessment techniques or erm treatment techniques, erm, and applying manual handling and things like that. So it's about: they're linked between the knowledge of and the application of. Umm,*

P: Yeah

So, do you think these may be potentially barriers to people say for example with, ummm, only one upper limb?

P: So, what? Could you give me an example?

Right so if we look at the 2a.2: select and use appropriate assessment techniques. Erm, it's er 'to be able to undertake and record a sensitive and detailed assessment': so it's this undertaking. What I'm, what I suppose I'm trying to get at is that physios, if you ask most physios what they do erm, they tend to wave their hands around a lot [laughing] and eventually come down to talking about using their hands. And this is something, when I did my Masters research I erm did a Delphi study with admissions tutors and there was a lot of erm "well I don't see how we could have a student who hadn't got two hands, err because we use our hands a lot and use touch a lot". Erm, and thinking about that when looking through the

*standards there's a lot of you've got to be able to apply, **know** it but also apply it and I'm, and **using** it and I'm reading that as that you know you couldn't become a physio with just the knowledge and the knowledge of how to apply it you've got to actually physically be able to apply it as well. Is that how that terminology is meant?*

P: Yeah. I mean that's kind of how I think about it. So I always think that these standards are about that knowledge understanding, but they're also about skills. They're also about what should someone be able to do at first point of entry to the register. Their employer might not require them to actually do it, so the might say 'well in this area with this particular employer I don't do x technique, but if it's kind of a necessary technique which is considered to be core to the profession they should be in here as kind of a necessary standard. Erm, how, I suppose in terms of someone's education and training how they meet that standard isn't kind of included in the standards of proficiency so there could be adjustments you could possibly put in place to make [unintelligible] talk about appropriate techniques and equipment so there might be some techniques they are unable to perform and others that they are and as long as they're aware of the range of the techniques that is reasonable and appropriate and they're kind of the techniques you'd expect then they probably meet the standard. It just about, it is also always around kind of the education provider who are in the better position to know, kind of having spoken to the disabled student what they are able to do physically, what they're not able to do, have that occupational health assessment perhaps and then make a reasonable informed decision about it. Erm, but I think, I think there'll always be limits. Erm, there'll always be some things, I suppose there'll always be some impairments which might be so severe that it's not possible to adjust.

Yeah.

P: Erm, put adjustments in place because if doing that would actually end up testing someone else's skills rather than that person, or they simply wouldn't be able to meet it so the, I suppose reasonable adjustments is just that isn't it?

Yeah

P: Sometimes you get to the point where it's unreasonable.

Yeah. Erm, I mean there was a big debate within allied health professions and also medicine, veterinary and dentistry: what, what is it that makes you the professional? Erm, and there was quite, some thread of argument that it was the clinical reasoning and that erm, anybody could take a blood test, anybody could do an x-ray, but it was the Dr's clinical reasoning that erm allowed them to diagnose, but I think erm, Dr's are in a different position to us, 'cos they often don't touch they patients very much do they? [Laughter] Whereas, physio we're in there erm, and hands in an it's a very contact profession. So as you say, I think as much as we

would be wanting to be open and welcoming to as many people with different impairments as possible there is going to be that point at where reasonable becomes too long a piece of string to make it practicable.

P: I think, I think the other thing I remember when a lot of this was being discussed the first time round is that there can sometime be kind of a concern you know “oo, God, you know we’re going to get people who’ve got x impairment who couldn’t possibly meet the standards who are going to apply for this programme. We’re going to have to accept them!” that kind of attitude.

Yeah

P: You used to hear anyway, which again seems to have disappeared, but that’s what you used to hear. And a lot of the time when you thought about it, you thought well actually not only is there something around kind of supporting disabled people here, but it’s also around making sure that disabled people have their own realistic assumptions about what they think they’re able to achieve.

Yeah

P: And that they’re helped in making sure that they’re not overly dissuaded and that they explore it with someone, but I suppose the example, you know some examples we used to get we used to think well actually I can’t imagine most disabled people wanting to put themselves in that position.

Yeah.

P: Things like if you knew you had some kind of condition which meant you had very very poor motor skills would you really be putting yourself forward to be doing scalpel work on someone’s foot?

Yeah [laughter] you wouldn’t go there would you?

P: You wouldn’t be applying in the first place.

No

P: So I suppose there is a balance somewhere, with kind of encouraging people to think about, overcoming those barriers, but also you know I think supporting people to make reasonable decisions based on their won kind of realistic insight about what they can do.

Yeah. Yes I agree there. I mean we’ve had a number of students with co-ordination problems who bump into things and knock themselves out, but over and above that they’re still quite good little physios. Erm, one comment that I have come through from my research is that one student; when I was asking about erm whether she felt willing to disclose on her application, during the application process: actually I

thought it was quite telling 'cos she said "well it wasn't that there was any negative information out there", it was just that she couldn't find any information at all which made her decide not to disclose. So I think that goes back to what we were saying earlier about we can make all these wonderful reports, but we need to make them visible. Erm, to..

P: And, absolutely and encourage people to disclose, because there's good reasons why it can help them.

Exactly, so that it's a dialogue rather than we don't want to know just 'cos we're going to say no you can't come on the course, we want to know so that we can help support you and get everything in place for when you're on the course. Erm..

P: Yes absolutely.

Do you think the term disclosure erm supports that positive promotion?

P: It sounds a bit formal doesn't it?

Yeah.

P: Yeah I mean I suppose yeah it does sound a bit formal. I think we probably do use it in our guidance, but I mean we probably just need to, that's one of kind of the areas of thinking about the language as well. I go, again I suppose this might come out of you research with disabled students I don't know whether you know language like just tell us rather than disclosure sounds a little bit friendlier and a bit less formal and officious.

Yeah.

P: And I think sometimes as a regulator you end up using [laughter] formal and officious language just because that's kind of what your statute uses, but we should try harder not to.

It's a very commonly used term within disability within higher education: disclosure. I was at a disability conference earlier on, no it was last year now, where some body actually raised the point: " well actually if we didn't keep talking about disclosure which is about secretive things and that would imply that it's something to be ashamed of and something to hid maybe we might get..

P: And it's like some one's forcing you to disclose as well [laughter]

Yeah. We might get a few more people telling us about issues erm, than anything else. Erm, I think that's all my questions now. Erm yeah. Do you think that the duties under the disability equality schemes : I know they've changed slightly since the equality Act came in, but do you think this idea of erm, to promote participation

is and promoting equality is one that erm, we should have as health care professionals?

P: Yeah. I mean, I think the principle is exactly the right one. Erm, I suppose when I think about it in the context erm, I suppose very narrowly when I think of it on the context of our role. I'm not sure how some parts of public organisations which are a bit more remote from kind of the point of delivery of care or education are quite able to achieve it, but certainly as a aim or as an ambition I don't think you'd find anybody who wouldn't sign up to that.

Yeah, yeah. Ok well thank you very much xxxxx for answering all those questions.

CSP Representative #2

P:Err, so that's kind of a slight blip in these figures, but so shall I give you the numbers?

Yes please.

P: Yes. So 19 people, and this is also broken down by country, but I'll just give you the totals.

Yeah, Thanks.

P:Erm, so that's 19 people have indicated that they are disabled, and as I said I unfortunately don't know what that means.

No

P: Umm, 895 for dyslexia, 213 for HI, 70 for mobility, 155 for VI and 161 have indicated other and we, as far as I recall on the form we don't, you know, prompt them: we don't say other, such as mental health blah blah blah or anything. It's just other. So we don't really have a sense, you know, of what that could include. Erm, and that gave us a total of 1513, which represents 3.64% of the membership, which is roughly similar to the 3.85, which is the percentage of the entire membership, the figure I gave you earlier.

Yeah, so they're sort of tallying aren't they with respect to that. Yeah, it's interesting to see that the number within the disabled students is a lot higher and as you say hopefully that will flow through. Erm, one of the interesting, one of the big issues that, when I do talks to clinical educators about supporting disabled students, I sometimes ask them if they were an admission tutor who they think would be a suitable candidate. And I put a slide up which is got somebody who's a, who's lipreading, somebody with a guide dog, somebody with an amputation and somebody in a wheelchair.

P: What was the one you said before the wheelchair?

Erm, and amputation, sorry, a lower limb amputation. Erm, and the clinicians all sort of go oh, yes the Visual Impairment, Hearing Impairment, fine and an amputee, that's fine and they have very much a big debate about er somebody who might be a wheelchair user. Do we have any idea of how many physiotherapists there are in the general population who are wheelchair users?

P: In the physiotherapist population did you say?

Yes.

P: Erm, well I kind of asked around about this and no one could think of anyone. Um, and of course we don't have the data on it. Um, anecdotally we are aware of one person who had an accident while they were a student in the past and they ended up in a wheelchair, but that was quite a long time ago. Um,...

Did they complete the course?

P: As far as I know yeah, but you know I can't; that was before my time. I heard it. So and we've certainly not had any one ever turn up to any of the disabled members' network meetings in a wheelchair. Umm, so I'm afraid I can't really give you a clear answer on that.

That's the sort of answer I was expecting to have, 'cos I, through the network working with the admissions tutors or closely with our admission tutor there doesn't sound to be any students out there who are training. I know erm, a clinician I was talking to had a student from – I think it was a student with Cerebral Palsy who was a wheelchair user part of the time, but not full time, she could also mobilise as well.

P: Well that's encouraging.

Yes, yes.

P: I mean the other, I don't know if you've ever spoken to, we do have a student officer here at the CSP.

Oh, right, and who's the student officer.

P: Erm, his name's xxxxx, and he's the person who kind of, in the organisation, who is closest to our student members and to, and is more likely to know if, you know, if people have come through as wheelchair users. I dunno if you want to perhaps...

I'll perhaps send him an email.

P: Yeah, I can send you his email, I'll just double check what it is, because he changed his name at one point...sorry, his name is xxxxx, so his email address is [email given]

Lovely, thank you. It will be interesting to see what information he knows about the student population. Erm, question number 6, that is because I; a lot of the literature that talks about physios with a disability, erm talks about the potential for them having a better empathetic link with patients. Erm, and I did a sort of literature review on empathy and disabled people, and what the literature says that people with a disability are looking for from their health professionals, erm and I think, you know I was wondering from that whether we as a profession erm could use this idea of more empathy or skills that disabled people have that maybe us within the non-disabled population might not have that they could bring towards their therapy. Do you think that would be a erm, I hesitate to say marketing aspect, because that sounds too, well it just doesn't sound appropriate, but an issue that we could sort of highlight a little more?

P: Well, I mean, two things I would say on that: Firstly, because I'm not a , you know, a professional I, you know , I don't really feel qualified in a sense to answer that, but I suppose just generally um, from my association with disabled members' groups and so forth I think that it's a slightly risky strategy, because it's kind of making generalisations potentially, you know, every disabled individual is different. Erm, and you know I mean some times it can work in reverse potentially, where you know 'I've got, I've dealt with this and that and I can't see why you can't!'

'Pull yourself together and get on with it!', yeah.

P: Yeah, um the Margaret Thatcher phenomenon. So, yeah.

I mean that is one of the comments that comes out in the literature: that it is a two way street and yes disabled people are all individuals and deal with their condition or disability very much on an individual basis, but I think part of this idea about having an empathy is this shared experience of erm of having to deal with challenges that people within the non-disabled community don't have to deal with, so this shared experience of having to erm confront the barriers that society puts in place against disabled people: as opposed to erm somebody having a hearing impairment having the same sort of difficulties as somebody having a visual impairment, yes they wouldn't have they'd be different difficulties, but they're still difficulties.

P: Umm, yeah I mean you know I think it, that kind of argument can be used but I think carefully and sparingly if you know what I mean? And with perhaps qualification or you know disabled people **may** have rather than **will** have an additional empathy. Erm...

Do you think we do enough as a profession to, erm actually, I mean my question says to enable more people to consider physiotherapy, but to actually go in a way one step further than that, to, so that more people realise that it is a profession that's open to erm people with disabilities?

P: Yeah, this came up, this sort of issue came up in the context of a discussion at ARC last year [2013] and it was actually a motion about socio-economic and ethnic diversity of the profession, as opposed to trying to extend it more to disabled people, but the way the CSP council responded to that motion was by making a number of points and they've said erm, oh I could just read you this bit if you like it might give you a sense so "we actually work with higher education institutions to welcome and support disabled student throughout their programmes through a range of activities including providing bespoke advise to careers advisors and potential applicants, promoting and embedding inclusivity within the pre-reg curriculum, ensuring that this message is consistently reinforced through our bulletins, workshops, forum and guidance, and information papers. Providing a higher profile inclusive and positive message through the promotion of the joint CSP/RNIB resource: 'Into Physio therapy. Welcoming and Supporting Disabled Students'. In addition to these activities inclusivity remains a critical element of our quality assurance requirements for accredited programmes and finally lobbying activity relating to workforce planning and education commissioning blah, blah, blah'. Erm, I don't know if that's helpful at all?

Yes, that is. My feeling is, and I have tried to do this, but ... I've tried to conduct a questionnaire with careers advisors because I think, you know, as the CSP stated in teir response to that motion, that erm as a profession they are doing their best to try and make it as open to all, but I'm not sure how far that message is getting out there. Erm, and certainly from my interviews with students with disabilities, they receive no sort of like negative feedback from, once they're at the universities it was before there. It was actually in their career choice and so one step back; so maybe teachers and careers advisors. So I did develop a questionnaire which I had 2 or maybe 3 attempts to distribute within the sort of local area to careers advisors, but unfortunately, at the moment I've hit a timing issue with regards to, erm, the governmental changes and taking careers advice from local authority to a national privatised, erm, companies, which means that my questionnaire has been falling to the wayside, unfortunately, I've hit a massive period of change. Because I don't think that careers advisors, erm, realise how open a profession physiotherapy is to people with different sorts of physical and mental or sort of neuro-diverse conditions that there are.

P: I mean that's probably true of careers advisors in terms of their attitudes to many professions isn't it?

Yeah, possibly yeah, and it was indicated on the lack of take up of my questionnaire, I didn't get any where with it, and it's something I still want to

pursue, because I think that's the point at which erm ,we're not getting further. It will be interesting to see what happens from the HCPC reviewing of their advice to disabled students and if that gets erm sent to a wider audience.

P: Yes, I think you're probably right that the problem does go further back, you know, before the point where people are considering possible training courses and future careers. Erm, again this might be something...[recording interrupted]

[Question about how the disabled network contributes to the working of the CSP]

P: ...kind of the ruling governing body of the CSP erm and the disabled members' network along with the other equality networks are also able to send delegations to the annual reps conference, erm so for example we've got 2 reps who are attending conference, which is in Cardiff in March and moving a motion, erm speaking to it and participating in that way. Erm, so they're sort of hooked it the whole decision making structure of the CSP as well as being a place where people can support each other either online or at specific meetings of the network which happen twice a year.

Yeah, so if the CSP produced a policy that the erm, that was forwarded to the disability network and the representatives there, that the network felt was erm going to make things err more challenging for them as physios with disability so therefore had a, they had an issue with, does that then get taken back to the central organisation?

P: Erm, a formal consultation in that way doesn't usually happen, but sometime informally erm, you know, say if there's a project happening within the organisation that had implications for disabled members then, say if somebody's writing a submission or you know setting up a new service or some thing, then the officer who's kind of leading on that may ask to come and speak to the disabled members network and you know discuss it, erm so it's more an informal consultation rather than...

Than a formal on?

P: Yeah.

Yeah, so it's more like participatory in the development process rather than we've developed this, what do you think of it?

P: Yeah, I'd say so.

Yeah, so therefore, probably you would argue that that is more inclusive, a more inclusive way of doing it, wouldn't it be?

P: It doesn't always happen but it some times happens.

Right, OK. Erm, so as, do you feel then, as we're moving forward in this now century that erm the prospects for disabled people within the profession are improving?

P: Umm, that wasn't on my list of questions.

No, I know, [laughter] it's just one that has just sort of..

P: One of those very subjective ones isn't it?

Yeah.

P: Erm, O, well I mean I suppose one would have to say yes when you look at the number of students, disabled students erm, you know it's a very hard one to judge. I mean, I think things are improving in many ways erm but I think that you know the current climate of austerity means that the bit is going on in some areas so for example we know that um funding's been cut for erm support services for deaf people and the access to work funding. You know so we've got over 200 hearing impaired physio in membership and we're not quite sure how that will impact on them. Erm, we also have anecdotal evidence that employers generally are sort of becoming less umm open to err recruiting disabled physios, but we don't have any hard data on it. Erm, so I don't know, I think it's a mixed picture really.

Yeah, I think your point about the current economic climate in the country is a very much a pertinent one and one that when I started doing my study I thought 'Oh, great this is great timing!' because as you say when jobs start to get harder to get it makes it difficult for everybody doesn't it and erm employer will often retreat into comfort zones. Erm, rather than you know being out there and err trying a new venture.

P: And there's; this perception often by employers that the disabled person is, erm, going to cost them, despite, you know, the availability of access to work funding, umm, you know, in many situations; notwithstanding what I've just said about cuts, for people services.

Do you think you have anything, as you say we've sort of covered the questions, do you have anything else you could add that might contribute towards my research?

P: Erm, well I suppose, I don't, I'm not sure whether there's been any, this is just me thinking off the top of my head, but umm, our disabled members' network is very, umm, dominated in a way by people with visual impairments and I think that's an historical thing, whereby there's been possibly a larger number of visually impaired physios in the past than what there currently is, and now you know that largest group, as I've given you the figures for, seems to be dyslexia, which I think is a reflection of a growing understanding about dyslexia as a conditions and more

people you know declaring the condition. I mean they were probably always there in the past, but it wasn't understood I guess, or picked up. Erm, so that's one thing that I think will gradually shift and change in terms of what's happening internally in the CSP and the organisation of disabled people, but I don't know if that's, that's just something that came into my head. Erm, have you spoken at all, or have you come across or do you know xxxx?

Yes, I've just actually written that down: the RNIB, because I've spoken to both xxx and xxx in the past. Erm, and I tried to contact them because we, as a university, we won the bid to do the research for the HCPC into their current document, the document that they're revisiting. They wanted some research done before hand on access to all the health professions that they cover for disabled students. I was part of the project team and I said well we need to speak to xxx and xxx from the RNIB, and I knew the unit had been disbanded, but I thought that xxx still worked at [university], but I've got both their phone numbers and their email addresses and they seem to have disappeared off the face of the earth! I can't contact either of them.

P: I don't know about Jane, I think Jane has retired, erm, but Karen you ought to be able to contact. Do you want to just check you've got the correct address? I've got [email]

Yeah, I'll try and touch base with her again because we've met at various point over the last few years. I met up with both of them probably a couple of year ago at a conference in Birmingham for the disability units within the universities; it was a conference from their support group on fitness to practice in health professions, so all of us ended up at that same conference and we were chatting then; and I know Karen's looking into this from, a similar sort of issue, but from the supporting clinical educators for supporting students out on placement.

P: Yeah, well she was doing a doctorate on it.

That's right yes.

P: I don't know, I'm not sure if she's finished it yet, but yeah that's what she was doing her.

Yeah, so she's doing her doctorate from that perspective and I'm doing mine from the disabled students' perspective so I said we thought if we put the two together we could write a book probably [laughs]

P: Yeah well that's right. I mean interestingly we've got a motion on the agenda for the ARC this year, which is kind of saying well you know there is a gap now that AHP assess has been abolished and it's basically calling on the CSP to think about what, to produce additional sort of advice and guidance and support for clinical

educators, academics, students and so on. So that should be quite an interesting debate.

Yeah. I will try and catch up with Karen over the next few months and see how she's getting on with her research and see sort of what, we can share notes. 'cos I think over recent weeks I've been looking at literature and I think, as you say, we are in a, going through a period of change which erm is happening in higher education, the widening participation in higher education, and then it's seeing if it follows through into the working environment. It would be interesting to see in, say, the statistics in 2018, if we've got 9% of people indicating they have a disability within the total membership, when all of these students who have a declared disability are out there in the working world.

P: Yeah I mean I think it's not likely to be that, but who knows?

I think also we have the issue of the, why people aren't declaring their disability when in the working world. Why is that? Why do they feel that, erm, they're comfortable to do it as a student, but they're not as a qualified member of staff?

P: Yeah, I think we could make an educated guess on that, but it would be good to sort of hear it from people wouldn't it?

But nobody's prepared to say it [laughing] not on, I think people, certainly I've been doing a lot of reading around about culture and organisational culture and erm there's an interesting article that's been written about physiotherapists who acquired a musculoskeletal injury whilst at work and the response being, well you're a physio you should have know better, erm and you've got it because you weren't doing the correct manoeuvres and this underlying assumption that physios have that knowledge and therefore shouldn't, that should protect them from acquiring an injury and if they do get one then it's their own fault, and funnily enough I'd been reading that and I'd had a bit of a twinge in my back and I went on a clinical visit and said 'oh, I've twinged my back and I know what I did: I was sitting her and I did that' and the physio said 'well it's your own fault then isn't it?' and I thought 'oh, yes' [laughter] there it is – live and kicking!

P: Lots of empathy

Yes. Not much no.

[laughter]

And then the other idea is that we're all very hard-working. So if you're then as an employer looking at somebody that, as you said, people seem to think that disabled people are going to cost them more,. They also seem to think they're going to have more days off sick than a non-disabled person err so you couple those two assumptions together and you have a reluctance to employ somebody

and maybe it's all around that? well probably is all around that, but erm, there's a point at which you have to stop data gathering and start writing up and doing studies like this you just start thinking 'oh, yes and I need to look into that and that would be interesting'

P: I know it's endless isn't it?

Yeah and my supervisor is saying .No! You don't need to look into that you need to write up what you've found out'.

P: How far through are you then?

Erm, I'm in my fourth year, so I started of doing some longitudinal following students through their course and interviewed them at various points and now I've been speaking to people like yourself at the CSP and also speaking to people at the HCPC to sort of look at the professions that the students are going into and also the governing bodies and their response to disability. What I haven't been able to look at, and I think, well I have been picking it up to an extent from the students who were saying, as a body of students they were erm, whenever they went to open days etc or interviews and disclosed their disability then they were made very welcome and everybody was very open and supportive, erm and you know, so that is coming through that the behaviours within the physios involved in those instances are erm very positive and very supporting, but it's what's the underlying culture and those basic assumptions that you don't talk about, but we expect a physio to be able to do that is interesting me at the moment ,and I think has an effect on how students are fitted into the profession.

P: Umm, yeah. We have noticed some increase in students, kind of, approaching the network for umm, with issues and problems that they're having as students. Things like university being unwilling to make reasonable adjustments, being undermined or ridiculed, erm, you know being told that they should de their won notes instead of the notes being done by a note taker, that sort of thing, you know, so I think we are getting more of those kind of where things go wrong sort of cases coming through to us, and this is partly linked with the absence now of AHP assess which previously would nave dealt with a lot of those.

Yeah so it's difficult isn't it? And I think a lot of that is I think from the environment, the economic environment and all having a knock on effect and people get back into their entrenched positions that they were in erm in previous eras. We sort of have a backward step, which is a real shame, 'cos I think, erm, with the document that Jane and Karen produced, and the document from the HCPC, erm, and the drive towards widening participation within Higher Education, things were moving very much is a very positive..

P: Direction

Yeah. Erm, do you have anything else to add?

P: *Erm, I don't think so, no. I think that's probably everything.*

OK than you very much for talking with me.

Appendix O: Analysis Tables of HCPC, CSP and QAA standards.

Table 1: Potential implications of standards of proficiency for different impairments (only includes those standards, or sub-standards that I assess to have a potential implication for people with impairments)				
HCPC Standards of Proficiency (HCPC 2013) This column only contains those standards which may have an impact		CSP codes (2013) QAA (2001)	Potential Implications for Disabled Students	
			May be difficult for people with / due to the following conditions (in the absence of reasonable adjustments)	People with disabilities may have increase effectiveness because of :
1. To be able to practise safely and effectively within their scope of practice	Know limits of practice	1.1 A3	Some mental health conditions in an acute episode AD/HD	Having developed coping strategies
	Manage own workload	1.2 2.2 2.3		
2. To be able to practise within the legal and ethical boundaries	Act in the service user's best interest	1.1 C2	Shared experience of disability Autistic spectrum disorders (ASD) Some mental health conditions	Shared experience of disability and discrimination
	Understand the need to respect and uphold the rights, dignity, values and autonomy of service users	1.2 1.3		
	Recognise that relationships with service users should be based on mutual respect and trust	2.1 3.1		
	Be able to exercise a professional duty of care	2.2		
3. Be able to maintain fitness to practise	maintain high standards of personal and professional conduct	2.2 C2	Some mental health conditions in an acute episode	Having developed coping strategies
	Understand the importance of maintaining their own health			
4. Be able to practise as an autonomous professional, exercising their own professional judgement	Be able to assess a professional situation, determine the nature and the severity of the problem and call upon the required knowledge and experience	1.1 A1	Severe AD/HD Severe dyslexia	Having developed coping strategies
	Be able to make reasoned decisions to initiate, continue, modify or cease techniques or procedures and record the decisions and reasoning appropriately	1.3		
	Be able to initiate resolution of problems and be able to exercise personal initiative			
	recognise that they are personally responsible for and must be able to justify their decision.			
5. be aware of the impact of culture, equality, and diversity on practice		3.1 3.2		Shared experience of discrimination
6. be able to practise in a non-discriminatory manner		3.1		
	be able to demonstrate effective and appropriate verbal and non-verbal skills in communicating information, advice, instruction and professional opinion to service users, colleagues and others	3.3 B2	Speech impairments Hearing impairments Visual Impairment	Focusing more on clients to understand them
	understand how communication skills			Paying more

Table 1: Potential implications of standards of proficiency for different impairments (only includes those standards, or sub-standards that I assess to have a potential implication for people with impairments)				
HCPC Standards of Proficiency (HCPC 2013) This column only contains those standards which may have an impact		CSP codes (2013) QAA (2001)	Potential Implications for Disabled Students	
			May be difficult for people with / due to the following conditions (in the absence of reasonable adjustments)	People with disabilities may have increase effectiveness because of :
affect assessment and engagement of service users and how communication should be modified to individual service users			ASD	attention to non-verbal and facial expression. Increased empathy to service users
be able to select, move between and use appropriate forms of verbal and non-verbal communication with service users and others			Mental health conditions which affect social engagement	
be aware of the characteristics and consequences of verbal and non-verbal communication and how this can be affected by multiple factors				
recognise the need to use interpersonal skills to encourage the active participation of service users				
8	be able to work appropriately with others	2.3 A2 3.4	Speech impairment	Focusing more on clients to understand them Paying more attention to non-verbal communication and facial expression
			Hearing Impairment	
	understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team		ASD	
	understand the need to engage service users and carers in planning and evaluating diagnostics, and therapeutic interventions to meet their needs and goals		Mental health conditions which affect social engagement	
	be able to contribute effectively to work undertaken as part of a multi-disciplinary team			
9	be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines	3.3	Dyslexia Dyspraxia Fine motor difficulties Attention deficit/hyperactivity disorder (AD/HD)	Coping strategies Exploring alternative means of recording information
	recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines	2.1		
10	be able to reflect on and review practice	4.1 A3	AD/HD	Having developed coping strategies
12	be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care	3.3 C1	Visual impairment Dyscalculia	

Table 1: Potential implications of standards of proficiency for different impairments (only includes those standards, or sub-standards that I assess to have a potential implication for people with impairments)				
HCPC Standards of Proficiency (HCPC 2013) This column only contains those standards which may have an impact		CSP codes (2013) QAA (2001)	Potential Implications for Disabled Students	
			May be difficult for people with / due to the following conditions (in the absence of reasonable adjustments)	People with disabilities may have increase effectiveness because of :
14. Be able to draw on appropriate knowledge and skills to inform practice.	be able to deliver and evaluate physiotherapy programmes	1.2 B1	Physical impairment	
	be able to gather appropriate information	4.1	Visual /hearing Impairment	
	be able to select and use appropriate assessment techniques		Physical impairment	
	be able to undertake or arrange investigations as appropriate		Visual/ physical impairment	
	be able to analyse and critically evaluate the information collected		Visual impairment	
	be able to demonstrate a logical and systematic approach to problem solving		Severe AD/HD or dyslexia	
	be able to conduct appropriate diagnostic or monitoring procedures, interventions, therapy, or other actions safely and effectively		Physical impairment	
	be able to select and apply safe and effective physiotherapy specific practice skills including manual therapy, exercise and movement, electrotherapeutic modalities and kindred approaches		Physical impairment	
	be able to use information and communication technologies		Visual impairment	
15. Understand the need to establish and maintain a safe practice environment	know and be able to apply appropriate moving and handling techniques	2.1	Physical impairment	
	be able to select appropriate personal protective equipment and use it correctly		Visual impairment	
	be able to establish safe environments for practice, which minimise risks to all, including the use of hazard control and particularly infection control		Visual impairment Severe AD/HD ASD	

Table 2: Potential implications of standards of conduct Performance and Ethics for Different Impairments			
HCPC Standards of Conduct, Performance and Ethics (HCPC 2012a) You must...	CSP Code (CSP 2013)	Potential Implications for Disabled Students	
		May be difficult for people with / due to the following conditions (in the absence of reasonable adjustments)	People with disabilities may have increase effectiveness because of :
1. act in the best interests of service users.	3.1	Shared experience of disability	Shared experience of disability and discrimination.
2. respect the confidentiality of service users.	2.1		
3. keep high standards of personal conduct.	2.2	Some mental health conditions in an acute episode	
4. You must provide any important information about your conduct and competence.	2.2		
5. keep your professional knowledge and skills up to date.	1.2 4.1		
6. act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.	1.2	Some mental health conditions in an acute episode	
7. communicate properly and effectively with service users and other practitioners.	3.3	Speech, Hearing or visual impairments ASD Mental health conditions which affect social engagement	Focusing more on clients to understand them. Paying more attention to non-verbal communication and facial expression. Displaying more empathy to service users.
8. effectively supervise tasks that you have asked other people to carry out.	4.2 4.3	Visual impairment	
9. get informed consent to provide care or services (so far as possible).	2.1		
10. keep accurate records.	3.4	Dyslexia Dyspraxia Fine motor difficulties Attention deficit/hyperactivity disorder (AD/HD)	Compensating for their difficulties Using more accessible language for service users Exploring alternative means of recording information
11. deal fairly and safely with the risks of infection.	2.1	Visual impairment	
12. limit your work or stop practising if your performance or judgement is affected by your health.	1.2		Having developed coping strategies
13. behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession.	2.2	Some mental health conditions in an acute episode	
14. make sure that any advertising you do is accurate.	2.2		

Appendix P: Student information on Cross Comparison Data Analysis.

The idea is to highlight areas of a participant's transcript that you feel are interesting and demonstrate the student's experience of disability. You select that phrase and give it a label. Then you look at the next transcript and see if similar issues are mentioned and label them with the same word. If, on subsequent ones, you identify a new label then you revisit the previous ones and see if that label exists there too.

An example is below based on the previous narrative summaries that you all received prior to the second interviews. Please don't feel you need to use these labels, use whatever you feel appropriate. Then I'll combine them. It might be worth having a group Skype session to discuss them later in March.

Thanks,

Jo

Narrative	Possible categories
<p>Participant 1:</p> <p>This student has a visual impairment which developed in adulthood. Unfortunately, due to numerous factors, they withdrew from their physiotherapy course during the first semester. However, their narrative is as important as students who have remained on their course so the data was included in the analysis.</p> <p>At school she enjoyed the sciences and therefore chose chemistry, biology and physics as A level subjects, continuing chemistry on to degree level. She enjoyed the area of medicinal research and worked in this for 5 year post graduation. However, she started to</p>	

<p>consider other career avenues as wanted more people contact.</p> <p>She spent some time working in the school liaison department and decided to move into teaching. She completed a PgCert and became a primary school teacher, working for 6-7 years in teaching. By this point she felt that paperwork was taking a priority over teaching, but also her eyesight was problematical and she was having a lot of operations. Her visual impairment started in 1999, but up until this point had not been an issue. After leaving teaching she considered what profession she could get involved with, using her skill set and bearing in mind the potential for further deterioration in her visual impairment. After some research she decided that physiotherapy and counselling were of interest to her. Therefore she arranged work experience in these areas and decided to apply for a physiotherapy programme. All of the research into this life choice was self directed, via the internet and visiting universities. During the work experience placements she did not disclose her condition and she acknowledged that her condition isn't obvious to people she meets. She considered that her visual impairment wasn't in the forefront of her reasoning in her research into this potential profession. She feels that although it may create challenges if you are determined to do something you will succeed.</p> <p>She only applied to the university nearest to her due to logistic decisions; settled in the area, hospital appointments and travel. She would be able to get to and from the university independently. She also knew that this course had a good reputation. She was looking forward to starting the course with a mixture of excitement</p>	<p>Onset of disability</p> <p>Reason for physio</p> <p>Non-disclosure</p> <p>Determination</p> <p>Reason for selecting</p>
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<p>and apprehension. She was aware of the demands of the course and her last time at university was 2000/2001. She was thinking about how she would manage and felt that the delay and hassle of applying for DSA was a battle to deal with, whilst settling into the new course. She was expecting a mixture of lectures and practical work and also placements. On starting university she felt that it was a 'big change'. She felt it was more intensive than expected and surprised as to how much material was presented electronically. The pace was very fast and she experienced feelings of 'playing catch up all the time'.</p> <p>In the first month of the course she had a lot going on. She was enjoying the course and was keen to learn, putting in 100% at university and at home. However, she felt even this time and effort was not enough. At this time she was also having more problems with her eyes. Each Sunday she was spending the whole day printing the lecture slides, which she found frustrating as she realised she couldn't keep up this pace. Consequently, she decided that this 'wasn't where she wanted to be'. Even with this experience her advice to someone with a visual impairment considering physiotherapy as a profession was not negative, but focused on being proactive and getting as much information and getting prepared as soon as possible, especially the DSA application process. Her advice for physiotherapy courses wishing to improve their accessibility was to provide an information pack in advance for students including advanced lecture notes, contact details for university support and outside support, e.g. RNIB, and advice for the period between the offer of a place and starting the</p>	<p>university: logistics – disability not considered</p> <p>Had to 'battle' the system</p> <p>Extra workload</p> <p>Proactive</p>
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<p>course. She also felt that a part-time delivery would have been more suitable for her, but these were a long way away and therefore not suitable for her. She didn't feel that she could have received any more support to assist her to remain on the course.</p>	<p>advice for universities</p>
<p>Participant 2:</p> <p>This student has a hearing impairment (HI) which developed in childhood. Her mother also has a hearing impairment, but her father and older sisters have no impairments. During her early childhood she had grommets and t tubes fitted, but these were not successful leaving her with bilateral perforated tympanic membranes. In primary school she failed her key stage one SATs tests 'miserably'. The teachers suggested she repeated the year, but her parents refused this and got extra tuition to help her catch up. She found this frustrating and felt that she was the 'less academic one in her group'. She feels that she has been playing 'catch up' all of her academic life. Outside of school she had dancing lessons where she felt she belonged. In the transition to senior school she was advised not to take the 11plus exam and to go to a comprehensive rather than grammar school. Both of her older sisters had gone to the grammar school and her Mum was worried about this choice of schooling. She was reassured by a teacher who suggested that her schooling should not be compared with that of her older sisters. At senior school her HI was 'ignored' and her parents got frustrated with this. However, she does not like 'making a fuss'. In year nine, after an audiologist appointment, she was advised to start wearing hearing aids and this got an instant result at school as there was now a visual reminder to the teachers</p>	<p>extra workload</p> <p>limiting aspirations?</p> <p>Lack of support</p>

<p>of her impairment. She felt that her best performance at school was in the sixth form as the group sizes were small and she 'thrived' in this environment.</p> <p>When considering her future career, as she comes from a medical family she was surrounded by 'medical stories' and she thinks this is where her interest in anatomy and physiology was stimulated. She asked her Dad to suggest a career which would combine this with her interest in dance and movement. He suggested physiotherapy. This was around the time that she got her hearing aids and she considers that the desire to pursue physiotherapy was the driver for her to improve her academic performance. She chose to do the triple sciences at GCSE. Her teachers advised against this, but her Dad supported her. She 'aced' this which she found a real 'esteem boost' and confirmed to her that she could continue to pursue physiotherapy as a career. However, she was not supported in this choice by school. The teachers were 'constantly' advising against physiotherapy. She feels that this reaction was due to the teachers 'seeing how she struggled with her learning' and didn't want her to experience disappointment as physiotherapy was so competitive. They advised her to become a PE teacher. Her initial reaction to this was 'O.K. ...I'm not good enough', but her parents encouraged her not to listen to the teachers and to strive for her goal. She acknowledged that she does have drive and determination to achieve her goals.</p> <p>She felt schooling was a struggle as supply teachers were often not aware of her HI and she found group discussion difficult. She</p>	<p>sport</p> <p>determined</p> <p>negative attitudes</p> <p>internalisation of negative attitudes</p>
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<p>found that this was also difficult socially as it was difficult to follow conversations. During her senior schooling this became easier as her peers began to adjust and accept her. This is an aspect that she 'hates' about her impairment: 'creating a fuss ... so I don't want that to be passed on to anyone else whose working with me or socialising with me'.</p> <p>When visiting university open days she felt the focus was more on having work experience rather than academic achievements. One admission tutor offered to discuss her options in clearing if she didn't get the grades, but this was not necessary as she did achieve them, although she puts this down to luck rather than her own endeavours. During the application process she was focused on the academic requirements rather than her HI. All comments made about her impairments were positive and suggested that this might be an advantage with patients. She got offers from two universities, but chose the course she is on as she was aware that it is 'one of the best in the country for physiotherapy' and she also like the feel of the university and found the tutors friendly when she visited. The distance between her home and the university was not a factor in her decision making. The main reason for choosing the course was the reputation of the course not the location.</p>	<p>open attitude in admissions process</p> <p>choice of university: reputation of course – not disability</p>
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Appendix Q: Categories and Themes developed by the Collaborative thematic analysis.

Categories developed independently Sally: Victoria: Alison: Lauren (ticks indicate participant's identifying the same category)	Agreed Themes (stage 4)	Overarching Analytical Themes (stage 5)
<p>Self-perception – development of /reflection on</p> <p>Realisation of importance of hearing for learning</p> <p>Realisation of own learning needs</p> <p>Identifying the +ve in the apparent –ve</p> <p>Avoided what found difficult ✓</p> <p>Doesn't like to 'make a fuss' (passive acceptance)</p> <p>Dislikes drawing attention to difficulties</p> <p>Extra tuition at school affected self-esteem = felt less academic</p> <p>Goal of applying to physio gave drive for A level studies</p> <p>Remained isolated despite struggling ✓✓</p> <p>Getting on with it alone</p> <p>Learned to be independent</p> <p>Felt 'cut off' in large groups due to Hearing impairment</p> <p>embarrassed</p> <p>Find time management difficult</p> <p>Decreased confidence in ability</p> <p>Having to justify self with achieving goals previously deemed unattainable</p> <p>Expected to have one strength</p> <p>Limiting aspirations – self doubt</p>	Self-Perception	Habitus – discussed in Chapter 6: The Development of Habitus, Capital and Strategies
<p>Reluctance to be open / disclose</p> <p>Being able to be open</p> <p>Shy about telling others</p> <p>Disclosure is negative word</p> <p>Feels like making excuses</p> <p>No - embarrassed</p> <p>Will disclose to future employers</p>	Disclosure	Negotiating Identity - discussed in Chapter 7: Practice in the Field
<p>Feel discriminated against by uni/society/peers</p> <p>Lack of understanding by others ✓</p> <p>Disability is negative word / concept</p> <p>Doesn't consider self to be disabled</p> <p>Hearing impairment presented as a barrier</p> <p>Felt other children would reject her due to hearing aids.</p>	Students' Attitudes towards disability	
<p>Worried about people's perceptions of them ✓</p> <p>No visible signs of impairment</p> <p>Symbols of disability – cane/ dog/ wheelchair ✓</p> <p>Upset about having to have hearing aids as these were visible</p> <p>Hearing aids were a visual reminder to teachers</p> <p>Feel people's perceptions of disabled people needs to change</p> <p>Improved awareness</p> <p>Being in the minority</p> <p>Each person has a different perception of disability ✓</p>	Perceptions of others	

Categories developed independently Sally: Victoria: Alison: Lauren (ticks indicate participant's identifying the same category)	Agreed Themes (stage 4)	Overarching Analytical Themes (stage 5)
High self-motivation ✓ Determination & proactive ✓✓ positive outlook differences = challenge not hindrance ✓ Adapt self to achieve goal ✓ Organised Better empathy with patients Making connections with people through similarities	Personal attributes	Capital – Discussed in Chapter 7: Practices within the Field
Lack of support Teachers assumed everything was fine as child didn't complain (passive role) Disability ignored by staff Teachers' attitudes reinforced poor self-esteem. Teachers discouraged choice of physiotherapy. Too much support at school will not allow student to develop appropriate independent coping strategies Poor school experience Not encouraged to aspire / no expectations from teachers	School support	
Family support vital ✓✓ Support from husband – emotional & financial Move to be nearer friends & family Parents frustrated by lack of support at school Parents' best intentions are sometimes limiting	Family support	Negotiating Learning Support discussed in Chapter 7: Practices within the Field
Previous degree Wanted to work with people Change in condition forced career change Self-reliant in finding information off internet Advice from qualified physiotherapists Preconceived ideas of physiotherapy being positive Didn't consider physiotherapy to be unsuitable career choice Lack of information for disabled students Receiving physiotherapy	Route into physiotherapy	
Logistics - Support at university allows living away from home Keeping known base (geographically) for support Transport – commutable from home Course needed to be accessible and appropriate Near to home to allow for treatment Strong disability network	Choice of university	
Excited Apprehensive – wondered how they would manage ✓ Worried that condition would prevent acceptance on course Worried about physical demands of course Career aspirations	Expectations	
Information difficult to retain Difficulty with mode of learning Learning method needs to be suited to individual ✓ positive learning experience	Learning / knowledge	

Categories developed independently Sally: Victoria: Alison: Lauren (ticks indicate participant's identifying the same category)	Agreed Themes (stage 4)	Overarching Analytical Themes (stage 5)
Focus on positive capabilities Focus on practical elements Experiential learning Fast paced learning Keen to learn Smaller group size made learning easier Learning opportunity for peers adjusting to students with disabilities	Learning/ knowledge	Negotiating Learning Support discussed in Chapter 7: Practices within the Field
Arranging DSA Experience increased fatigue Extra effort & work harder More demanding than initially expected Playing catch up Frustration with time consuming preparation of materials Acknowledging that physio is a demanding job with work pressures which need managing Extra tuition to catch up at school Communication strategies tiring Overwhelmed by workload Intensity and pace of lectures overwhelming Frustrated as enjoying the course, but struggling to keep up Frustration of constantly having to adapt to different environments	Effort	
Has coping strategies in place Plans workload Pacing Managing symptoms Denial Solitude Familiar routine Lack of engagement with support	Coping strategies	
All students have different challenges All students have frustrations with unreliable virtual platforms Different students have different strengths and weaknesses All people have differences, not just disabled people Concerns about starting work same as peers	Same experience as non-disabled students	
Difficulties arranging DSA & Assessments Poor communication between university & placement Current situation isn't fool proof University supportive in general University support best yet Reassurance that there is support positive experience of range of support at uni Support at uni allows living away from home Surprised at help from university Needed specialist equipment and time to learn how to use this People helpful now diagnosed	Support	

Categories developed independently Sally: Victoria: Alison: Lauren (ticks indicate participant's identifying the same category)	Agreed Themes (stage 4)	Overarching Analytical Themes (stage 5)
Realisation that help can be positive Peers learn to adapt communication styles	Support	
Clinical Educators struggled to support disabled student Placements challenging, but finds this positive Frustration as lack of consideration Friendly team environment helped decrease worry Hope you will receive considerations	Clinical Placements	
Apply for DSA early Gain experience Contact university early & establish a rapport	Advice for future students	Recommendations
Information pack Part-time delivery Training in computer software/ hardware in advance of course Negative comments from physiotherapist Changes in support for disabilities within the profession Not aware of CSP/ HCPC documents Not aware of CSP disability network	Advice for profession / course	
Assistance with informing clinical placements of learning needs Need to consider the fatigue factor Get to know student as a person Effective & efficient more important than pretty Improved understanding	Advice for clinical placements	

Appendix R: Current and Future Publications associated with this Research

Current

Opie.J. (2011) “*The Transition into Physiotherapy for Students with Disabilities*”. 3rd ER-WCPT Congress. Vienna.

Opie.J. (2013) “*The Concept of Empathy and Health Care Professionals with Disabilities: A Meta synthesis*”. Poster Presentation. Birmingham. CSP Conference.

Opie, J., Cunliffe. E., East-O’Keeffe. R., Grace. E., and Karlsson. A. (2014) ‘*Experiences of Disabled Students within Physiotherapy Education.*’ Birmingham. CSP Conference..

Opie.J (2015) “*Are Fitness to Practise Requirements Restricting the Access of Disabled Students to the Health and Care Professions?*” Poster Presentation. Coventry NAEP conference.

Opie.J., and Parkes.S. (2015) ‘*Empathy: Can it be Enhanced by Learning from the Interactions Between Healthcare Professionals with a Disability and their Patients?*’ Poster presentation. Singapore.WCPT congress.

Opie.J. (abstracts submitted) ‘*Are Fitness to Practise Assessments of Physiotherapy Students with Disabilities Discriminatory?*’ AND ‘*Borrowing from Occupational Therapy: Using the Kawa model in Physiotherapy*

Research and Reflection. Abstracts submitted for 4th ER-WCPT congress.
Liverpool. November 2016.

Spring/Summer 2016 Arrange to present findings to the CSP and HCPC.

In draft:

Opie.J., and Parkes.S (in draft) *“Using the Experiences of Health and Care Professionals with Disabilities to Teach Empathy to Health and Care professional Students”*.

Planned Papers:

“Negotiation of Identity by Disabled Physiotherapy Students”.

“Climbing Everest: The experience of disabled physiotherapy students”.

“The Paradox of the Perfect Physiotherapist: the Doxa towards Disability within the Physiotherapy Profession”

Are Fitness to Practise Assessments of Disabled Health and Care Students with Disabilities Discriminatory?”

“Using the Kawa model within Research”

“A Bourdieusian analysis of physiotherapy education as experienced by Disabled Physiotherapy students”

“Using the Kawa Model to aid Reflection”.